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Equality Standards for Health Insurance Coverage: Will The Mental Health Parity and Addiction Equity Act End the Discrimination?

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ARTICLE

EQUALITY STANDARDS FOR HEALTH
INSURANCE COVERAGE: WILL THE
MENTAL HEALTH PARITY AND
ADDICTION EQUITY ACT END THE
DISCRIMINATION?

ELLEN WEBER*

Congress enacted the Mental Health Parity and Addiction Equity Act in 2008 to end discriminatory health insurance coverage for persons with mental health and substance use disorders in large employer health plans. Adopting a comprehensive regulatory approach akin to that of other civil rights laws, the Parity Act requires “equity” in all plan features, including cost-sharing, durational limits and, most critically, the plan management practices that are used to deny many families medically necessary behavioral health care. Beginning in 2014, all health plans regulated by the Affordable Care Act must also comply with parity standards, effectively ending the second-class insurance status of persons with these disorders. With the legal framework in place, this Article examines whether the Parity Act will achieve its promise of equitable health care coverage. It concludes that two structural features—the complexity of the Act’s standards and the health plan’s control of all data needed to assess compliance—render enforcement by consumers exceedingly difficult. Enforcement is further jeopardized by the federal regulators’ failure to articulate a standard to implement the most fundamental aspect of the law—the required scope of behavioral health services—and to provide sufficient guidance on the law’s most

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contentious provision—regulation of plan management practices. To address these enforcement limitations, this Article provides a detailed explanation of the Parity Act’s standards, offers interpretive guidance to resolve key questions, and recommends implementation strategies to enhance consumer notification and demonstration of parity compliance. Additional, yet modest, compliance requirements are needed to ensure that the Parity Act achieves its remedial goal.

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*Dealing equally with health care for mental, substance use, and general health conditions requires a fundamental change in how we as a society and health care system think about and respond to these problems and illnesses. Mental and substance use problems and illnesses should not be viewed as separate from and unrelated to overall health and general health care.***

INTRODUCTION

Inequality has long been the defining characteristic in health insurance coverage for addiction and mental health treatment. Cost-sharing is frequently higher for addiction and mental health treatment than for other medical care, limitations on length of care are more restrictive, and financial caps on a health plan’s annual expenditures for addiction treatment are common.¹ An individual seeking care for addiction and mental illness must often obtain the insurer’s approval even before seeing a clinician and “fail first” in a less expensive level of care prior to receiving the services the clinician deemed most appropriate. These standards would cripple the delivery of health care for other medical conditions.²

** Harvey V. Fineberg, Inst. of Med., *Improving the Quality of Health Care for Mental and Substance-Use Conditions*, at viii (2006).

¹ See U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-00-95, *MENTAL HEALTH PARITY ACT: DESPITE NEW FEDERAL STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED* 6-8 (2000), available at www.gao.gov/assets/240/230309.pdf (describing plan design features that were common even after the enactment of the Mental Health Parity Act of 1996); Michael Carter & Robert Landau, *Employers Face Challenges with New Mental Health Parity Act*, 41 COMP. & BENEFITS REV. 39, 43-44 (2009) (explaining that typical preferred provider plan coverage for mental health is “substantially less” than medical benefits coverage because of durational limits on hospitalization and outpatient care for mental health services and higher cost-sharing).

² Persons with addiction and mental health conditions are by no means the only individuals with chronic conditions who experience health insurance barriers to obtaining essential healthcare.

Against this backdrop, the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008³ (Parity Act) was, by any measure, a significant victory in regulating discriminatory health insurance practices that have barred access to health care for many people with addiction and mental health disorders. Fifteen years after the introduction of the first mental health parity bill,⁴ Congress began to regulate both the design of health benefits and the medical management tools that often determine whether a patient will receive necessary care. The law seeks to end discriminatory insurance standards that have perpetuated stigma, sacrificed critical care to cost-control measures, and ignored scientific knowledge demonstrating the unity of body and mind in matters of health.⁵ Whether this law will succeed in achieving its important goals depends on the proper enforcement of a complex regulation and the resolution of several key standards that will define the meaning of equal health coverage and care

See Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 26-32 (2004) (stating that health insurance “fails to cover the services persons with disabilities most need for independence and health,” such as durable equipment and assistive technologies and ongoing rehabilitative therapies to address chronic, as opposed to acute, conditions). The distinguishing feature for persons with addiction and mental health disorders is that these conditions have been subject to more restrictive standards, in large part because they are deemed to be the “fault of” and subject to manipulation by the patient. Treatment is perceived as having less-objective indicators of a “cure,” and the providers of such services are deemed to need “oversight” in their clinical judgments. *See infra* notes 61-69 and accompanying discussion. Thus, individuals who suffer from these conditions are stigmatized and discounted, as are the healthcare services and practitioners. As described in the legislative history of the Mental Health Parity and Addiction Equity Act, “[m]ental health and substance abuse conditions are the only disorders that have been systematically and unfairly excluded from equal coverage. Unlike mental health, the usual medical/surgical categorical exclusions made by insurers are for treatments or procedures . . . not for a whole class of diagnoses.” H.R. REP. NO. 110-374(II), at 15 (2007); *cf.* Bagenstos, *supra*, at 29-30 (claiming that although the exclusion and capping of benefits for persons with mental health conditions is a major problem, private health insurance adversely affects persons with disabilities more significantly through its emphasis on acute care and medical necessity standards that require evidence that the service will improve the condition as opposed to maintain functional capacity).

³ Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3861 (2008).

⁴ For a history of federal parity legislation, *see* H.R. REP. NO. 110-374(I), at 13-19 (2007); Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404 (2010); Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63 (1997) (describing legislative proposals that culminated in the enactment of the Mental Health Parity Act of 1996); Sonja B. Starr, *Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction Treatment*, 111 YALE L.J. 2321, 2359-60 (2002) (describing proposed substance abuse parity legislation).

⁵ The Surgeon General reported in 1999 that “everyday language tends to encourage a misperception that ‘mental health’ or ‘mental illness’ is unrelated to ‘physical health’ or ‘physical illness.’ In fact, the two are inseparable.” U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 5 (1999), *available at* profiles.nlm.nih.gov/ps/access/NNBBHS.pdf.

for mental health and substance use disorders. This Article seeks to promote an understanding of the Parity Act's non-discrimination standards, respond to interpretive gaps that undermine enforcement, and recommend enforcement strategies that will help achieve the law's remedial goals.

The Parity Act requires group health plans⁶ to equalize health benefits for addiction and mental health and medical benefits in many fundamental ways. First, it specifically prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health and substance use disorder benefits. Second, patients can no longer be denied insurance reimbursement when they reach an arbitrary lifetime or annual spending cap imposed solely on mental health or substance use disorder care.⁷ While an employer is not required to offer any health insurance coverage for addiction or mental health care,⁸ the coverage of any service for these disorders renders the plan subject to the Parity Act in a comprehensive fashion.⁹ Third, and most importantly, the parity regulations impose non-discrimination standards on medical management practices, medical necessity determinations, and provider network and compensation practices—classified as “non-quantitative treatment limitations.” These practices, which have operated in the shadows to limit access to the most expensive care, have forced many insured individuals to pay higher costs through out-of-network care, obtain care in the publicly funded health care

⁶ The Parity Act regulates health plans offered by large employers, while plans offered in the “small employer” market—those with fifty or fewer employees—and individual (non-group) market policies are exempt. 29 U.S.C.A. § 1185a(c)(1) (Westlaw 2012). The Patient Protection and Affordable Care Act (ACA), however, extends the parity requirements to the individual market for qualified health plans sold in or outside the Health Benefit Exchange. Pub. L. No. 111-148, §§ 1311(j), 1562(c)(4), 124 Stat. 119, 181, 265-277 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. Under U.S. Department of Health and Human Services regulations, the ACA also extends parity requirements to qualified health plans sold in the small group market. 78 Fed. Reg. 12834 (Feb. 25, 2013). This Article addresses parity standards related to large group health plans and, by extension under the ACA, qualified health plans and plans purchased by small employers and individuals.

⁷ The Mental Health Parity Act of 1996 barred annual and lifetime dollar limits for mental health disorder benefits that were less than the benefit limits for medical care, but it did not extend this protection to substance use disorder benefits. Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, Pub. L. No. 104-204, §§ 701-702, 712, 110 Stat. 2874, 2944 (1996). The 1996 parity law explicitly allowed group health plans to impose “cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity” on mental health disorders (and substance use disorder benefits) even if such standards were not imposed on other medical benefits. *Id.* § 712(b)(2). This limited parity protection was easily circumvented by the benefit designs that are now addressed in the Parity Act.

⁸ 26 U.S.C.A. § 9812(b)(1) (Westlaw 2012); 29 U.S.C.A. § 1185a(b)(1) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(b)(1) (Westlaw 2012).

⁹ For a description of the regulatory standards, see *infra* Part II.

system, or forgo treatment entirely.¹⁰ Finally, the Parity Act offers a remedy for health insurance discrimination that was promised, but never realized, under the Americans with Disabilities Act (ADA).¹¹

The true test of any reform legislation, however, is whether it is operationalized in a way that will effectively remedy the targeted inequity.¹² Four years after the enactment of the Parity Act,¹³ advocates point to fault lines in enforcement.¹⁴ Federal regulators have yet to promulgate a final rule for employer-based plans, and the Centers for Medicare and Medicaid Services (CMS) have issued no rules for Medicaid managed care plans. The Interim Final Rule (IFR),¹⁵ while far-reaching, provides incomplete guidance on the non-discrimination standard for plan management features (e.g., non-quantitative treatment limitations) and is purposefully silent on whether the law regulates the “scope of services” that must be offered for mental health and substance use disorder benefits.¹⁶ The articulation of these standards will determine whether millions of individuals currently receiving mental

¹⁰ Richard G. Frank et al., *The Politics and Economics of Mental Health Parity*, 16 HEALTH AFF. 108, 111, 117 (1997); Steven S. Sharfstein, *Will Parity in Coverage Result in Better Mental Health Care?*, 346 NEW ENG. J. MED. 1030 (2002). See discussion *infra* accompanying notes 73-85 and 92-97.

¹¹ See discussion *infra* accompanying notes 29-43.

¹² For example, overly restrictive Supreme Court interpretations of the disability definition under the Americans with Disabilities Act, e.g., *Sutton v. United Air Lines*, 527 U.S. 471 (1999); *Murphy v. UPS*, 527 U.S. 516 (1999); *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555 (1999); *Toyota Motor Mfg. Ky., Inc. v. Williams*, 534 U.S. 184 (2002), eliminated protections for many individuals that Congress intended to protect. See ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2, 122 Stat. 3553 (codified at 42 U.S.C.A. § 12101(a)(4)-(7), (b) (Westlaw 2012).

¹³ The Parity Act applied to health plans for any plan year following October 2009. Pub. L. No. 110-343, § 512(e), 122 Stat. 3891 (2008). The Interim Final Rule was applicable for plan years beginning on July 1, 2010. 26 C.F.R. § 54.9812-1T(i) (Westlaw 2013); 29 C.F.R. § 2590.712(i) (Westlaw 2013); 45 C.F.R. § 146.136(i) (Westlaw 2013). Thus, for health plans that follow a calendar year, the law has been fully effective since January 2011.

¹⁴ In March 2011, the sponsors of the Parity Act, former Representatives James Ramstad and Patrick Kennedy, announced a Patriots for Parity Campaign to draw public attention to gaps in the enforcement of the Parity Act. Representative James Ramstad & Representative Patrick Kennedy, Remarks at the National Press Club Luncheon (Mar. 14, 2012), available at press.org/news-multimedia/videos/npc-luncheon-patrick-kennedy-jim-ramstad. Congressionally sponsored field hearings have been announced for six cities. See *Parity Field Hearings*, PARITY IMPLEMENTATION COALITION, parityispersonal.org/Parity_Field_Hearings (last visited Aug. 14, 2012). Testimony at the June 2012 field hearing in the Washington, D.C., metropolitan area highlighted the continuing inequity in coverage for mental health and substance use disorders and the need for federal regulators to promulgate a final rule. *Id.*

¹⁵ Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (Feb. 2, 2010) (codified at 29 C.F.R. pt. 2590, 45 C.F.R. pt. 146, and 26 C.F.R. pt. 54).

¹⁶ *Id.* at 5416-17. (“These regulations do not address the scope of services issue. The Departments invite comments on whether and to what extent [the Parity Act] addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage.”).

health and substance use disorder care through large employer or Medicaid managed care plans¹⁷ will receive care that conforms to clinical care standards or will continue to receive less comprehensive care than individuals receive for other medical conditions.

These standards are equally important for millions of uninsured or underinsured individuals who will enroll in private or public insurance under the Affordable Care Act (ACA).¹⁸ The ACA will bring about the largest expansion of substance use disorder care in our Nation's history.¹⁹ It requires all individual and small group plans to include mental health and substance use disorder services as an essential health benefit,²⁰ and those services must be provided at parity with medical services. The rules that govern the scope of and dictate access to those

¹⁷ The Parity Act applies to Medicaid services that are delivered through a managed care organization or a Pre-Paid Inpatient Health Plan as well as the Children's Health Insurance Program. Letter from Cindy Mann, Dir., Center for Medicaid and State Operations, to State Health Officers, SHO 09-014 CHIPRA #9 (Nov. 4, 2009), *available at* downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf. Forty-seven states and the District of Columbia currently deliver Medicaid through managed care organizations to some or all enrollees, but these states often carve out mental health and/or substance use treatment and reimburse on a fee-for-service basis. KAISER COMM'N ON MEDICAID & THE UNINSURED, A PROFILE OF MEDICAID MANAGED CARE PROGRAMS IN 2010: FINDINGS FROM A 50-STATE SURVEY 2, 3 (2011), *available at* www.kff.org/medicaid/upload/8220-ES.pdf. Non-managed care carve-out arrangements are not subject to parity requirements. *See* Letter from Mann, *supra*.

The Department of Health and Human Services has estimated that, with mandatory issue of health insurance, an additional 4.8 million individuals in the individual market alone will gain coverage for substance use disorders, and an additional 2.3 million individuals will gain coverage for mental health services. ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., ESSENTIAL HEALTH BENEFITS: INDIVIDUAL MARKET COVERAGE, ASPE ISSUE BRIEF (Dec. 16, 2011), *available at* aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.pdf (stating that increased coverage is based on estimates that thirty-four percent of individuals and families that purchase their own insurance do not have coverage for substance use disorder services, and eighteen percent do not have coverage for mental health services). In addition, the expansion of Medicaid under the ACA to cover individuals up to 133% of poverty will extend these protections to many more individuals. The benchmark or benchmark-equivalent plan that must be offered to these Medicaid recipients must provide the essential health benefits package including mental health and substance use disorder services. The ACA extends the parity standards to the treatment limitations and financial requirements of these benchmark plans. Pub. L. No. 111-148, § 2001(c), 124 Stat. 119, 271 (2010).

¹⁹ Richard Frank, Ph.D., Remarks at the Closing Addiction Treatment Gap Winter Learning Session (Feb. 24, 2011) (notes on file with author); *see also* Jeffrey A. Buck, *The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act*, 30 HEALTH AFF. 1402, 1403 (2011) (observing that the unique service system for substance use disorder treatment will change as a result of healthcare reform, and "[t]he degree of this change may be as great as, or greater than, that for any other area of health care").

²⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119, 163 (2010).

services determine whether “behavioral health care”²¹ will become synonymous with “health care” or will remain a separate, non-integrated care system.

This Article asserts that Congress’s goal in enacting the Parity Act was to align insurance standards with scientific advances and clinical practice in the treatment of behavioral health conditions and simultaneously align insurance coverage for mental health and substance use disorders to the coverage for other medical services. Enforcement efforts should be guided by how well they will achieve these ends. This Article demonstrates how the Parity Act, in conjunction with the ACA, places our nation’s health care system on a path to achieving a more unified vision of behavioral and physical health care.

Part I of this Article explores the political, social, and economic forces leading to the enactment of comprehensive parity legislation in 2008. It describes the insurance regulation of mental health and substance use disorders services through managed behavioral health care organizations and the impact of that regulation on both an individual patient and systems scale. Excessive management of behavioral health benefits,²² among other factors, led to the enactment of the Parity Act, and identifying the scope of discrimination helps inform the measures that are needed to ensure equity. Part II describes the key statutory and regulatory standards in the Parity Act that were enacted to address burdensome and discriminatory limitations on care. Part III analyzes the two key parity standards that remain open to interpretation—the “scope of services” standard and “comparability” of medical management standard—and offers interpretive guidance to facilitate enforcement. Part IV offers recommendations to ensure better enforcement of the Parity Act through the promulgation of a final federal rule, mandatory demonstration of parity compliance, state review of plan compliance for parity, and health plan accreditation standards. These recommendations respond to three structural features of the Parity Act—complexity of standards, control of information, and capacity of consumers to

²¹ The terms “behavioral health” and “mental health and substance use disorders” are used interchangeably in this Article. The terms “medical benefits” and “medical services” are used interchangeably and refer to “medical/surgical benefits” as used in the Parity Act.

²² Consumer backlash against managed care cost-containment practices have led to some modifications in industry practices in the medical context. See Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH POL’Y L. & ETHICS 93, 98 (2006) (explaining that consumer dismay translated into the adoption of preferred-provider models to allow reimbursement for out-of-network providers with less of a penalty and limitations on financial incentives to doctors who recommend fewer high-cost treatments). As limited as these actions have been in addressing “the most serious process and equity questions” in accessing medical benefits, *id.*, they arguably did not even apply to managed behavioral health care organizations that separately manage mental health and addiction disorders. See *infra* Part I.A.

enforce—that render current enforcement efforts difficult. These remedial steps are also essential to ensure that health plans offered under the ACA are parity-compliant. The Article concludes with observations about the synergistic effect of health care reform and the Parity Act to incentivize coverage and delivery of comprehensive addiction and mental health benefits.

I. INSURANCE INDUSTRY PRACTICES AND RESTRICTIONS ON CARE: FACTORS LEADING TO THE ENACTMENT OF THE PARITY ACT

The sponsors of the Parity Act heralded the law as a civil rights statute that sets equality standards for the delivery of mental health and substance use disorder services.²³ The Parity Act repudiated insurance practices that have allowed disparate cost-sharing and limitations on the duration and setting of care for mental health and substance use disorders services. Congress stepped in after federal disability discrimination laws were interpreted to offer no remedy for disparate insurance standards, and evidence demonstrated that more restrictive coverage denied appropriate care and was not justified as a cost-control measure.

To fully understand the reach of the parity law and regulation, and the theoretical framework for addressing the key unresolved regulatory issues, it is important to identify the health insurance practices that gave rise to the law. The following section examines the failure of federal disability rights statutes to address unequal insurance coverage for the treatment of mental health and substance use disorders, and it describes the unique insurance practices that have regulated the availability and scope of these services in the private market since the 1980s. The section ends with a description of several key compromises that Congress made to rectify this historical inequity, albeit incompletely.

²³ 153 CONG. REC. H15,449, 15,450 (2007) (statement of Rep. Patrick Kennedy) (“[I]nsurance companies don’t treat [addiction and mental illness] the same for insurance purposes We want to see the discrimination against mental illnesses end”); *id.* at 15,450 (statement of Rep. James Ramstad) (“[I]t’s time to end the discrimination against people suffering the ravages of mental illness and chemical addiction. It’s time to end the higher copayments, higher deductibles, the out-of-pocket costs and limited treatment stays. . . . It’s time to treat mental illness and chemical addiction under the same rules as physical illnesses.”).

A. PRE-PARITY ACT INSURANCE REGULATION OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE

1. *Health Insurance Discrimination and Remedies Under the Americans with Disabilities Act*

Health insurance, by its very nature, discriminates in coverage,²⁴ drawing distinctions based on age, sex, medical history, and health status, as well as on which medical treatments, procedures, and prescription drugs are reimbursable.²⁵ Insurance carriers profit from attracting younger and healthier populations, and they design policies to achieve this end.²⁶ The principle of actuarial fairness, which governs considerations of unfair discrimination in insurance,²⁷ is based on the premise that each individual should bear financial responsibility for his or her own risk of incurring medical expenses. Coverage and pricing decisions are designed to ensure that persons presenting comparable medical risk are segmented into homogeneous pools so that a person

²⁴ See DEBORAH HELLMAN, WHEN IS DISCRIMINATION WRONG? 115 (2008) (noting that state insurance laws draw distinctions based on actuarial data that demonstrates “actual differences in the likelihood that each customer will file a claim during the policy period”); Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 81-83, 85-91 (2005).

²⁵ A range of civil rights laws limit, to varying degrees, distinctions based on sex, disability, and age in employer-based health insurance coverage and pricing. See Crossley, *supra* note 24, at 85-99. Fewer protections exist when health insurance is purchased outside the employment context. But, as Professor Crossley observes, the non-discrimination standards that apply even to employer-based health insurance under Title VII, the Americans with Disabilities Act, and the Age Discrimination Employment Act (ADEA) vary dramatically based on the protected class. *Id.* Protections against disability and age discrimination reach only disparate treatment, while gender-based protections extend to disparate-impact discrimination. *Id.* at 91, 93, 95-96 (noting that the ADEA actually allows employers to give “lesser benefits” to older employees as compared to those given to younger employees). Actuarial fairness standards also limit protections for disability and age-based discrimination but do not apply to gender classifications. *Id.* at 107-08. See also Sharona Hoffman, *AIDS Caps, Contraceptive Coverage, and the Law: An Analysis of the Fed. Anti-Discrimination Statutes’ Applicability to Health Insurance*, 23 CARDOZO L. REV. 1315 (2002).

²⁶ Crossley, *supra* note 24, at 82. The ACA, when fully implemented in 2014, will end many of the most exclusionary practices in the individual and small group markets by eliminating underwriting practices that base coverage and pricing on an individual’s health status, Pub. L. No. 111-148, § 2701, 124 Stat. 119, 155 (2010), and by prohibiting denials of care based on a person’s pre-existing health condition. *Id.* § 2704. In setting premiums, qualified health plans will be limited to considerations of age, type of coverage (family or individual), geographic rating area, and smoking status. *Id.* § 2701.

²⁷ Crossley, *supra* note 24, at 109-10 (describing state laws barring unfair trade practices in health insurance, which are based on the National Association of Insurance Commissioners’ model act, which bans health insurers from “unfair discrimination between individuals of the same class and of essentially the same hazard”).

with a “healthier” profile is not required to subsidize the costs of care for a person with riskier health characteristics.²⁸

Perhaps not surprisingly, then, when the ADA was enacted in 1990, it prohibited insurance discrimination against individuals with disabilities²⁹ but incorporated the principle of actuarial fairness into its non-discrimination standard. The insurance provision, which became known as the “safe-harbor” provision,³⁰ offered limited protection against insurance discrimination. By its terms, the ADA permits health insurance plans to create disability-based distinctions and apply underwriting and risk classifications that adversely affect persons with disabilities as long as the plan is not a subterfuge to evade the purposes of the ADA.³¹ Guidance from the Equal Employment Opportunity Commission (EEOC) in the early 1990s stated that a plan could satisfy the “no subterfuge” standard by demonstrating that any disability-related distinctions are justified by the risks or costs associated with that disability.³² Legitimate actuarial data using risk calculations that are not outdated, inaccurate, or based on false stereotypes related to disability would be sufficient proof, as would evidence that the disability classification is necessary to prevent plan insolvency or unacceptable changes in coverage or premiums that will subject the plan to adverse selection.³³ The legislative history on the insurance provision affirms the centrality of the actuarial fairness standard, explaining that “a person with a disability cannot be denied insurance or be subjected to different terms or conditions of insurance based on disability *alone*.”³⁴

²⁸ *Id.* at 77-79 (setting out Professor Deborah Stone’s competing concepts of actuarial fairness and solidarity in insurance coverage and pricing); Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL’Y & L. 287 (1993).

²⁹ Titles I, II, and III of the ADA prohibit employers, public entity-sponsored health plans, and insurance companies, respectively, from discriminating against individuals with disabilities in health insurance. See Title I, 42 U.S.C.A. § 12101 et seq. (Westlaw 2012); 29 C.F.R. § 1630.4(a)(vi) (Westlaw 2012); Title II, 42 U.S.C.A. § 12131 et seq. (Westlaw 2012); 28 C.F.R. § 35.140(a) (Westlaw 2013); Title III, 42 U.S.C.A. § 12181 et seq. (Westlaw 2012); 28 C.F.R. §§ 36.104, 36.202 (Westlaw 2013).

³⁰ See *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 562 (7th Cir. 1999) (noting that the ADA’s insurance provision “is obviously intended for the benefit of insurance companies rather than plaintiffs”).

³¹ 42 U.S.C.A. § 12201(c) (Westlaw 2013).

³² EEOC, NOTICE NO. 915.002, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE (1993), available at www.eeoc.gov/policy/docs/health.html (identifying a framework for evaluating whether an employer-provided health insurance plan violates the ADA, which looks first to whether the challenged term is a disability-based distinction and, second, to whether the disability-based distinction falls within the protection of the ADA’s safe-harbor provision).

³³ *Id.*; see *infra* note 49 (explaining “adverse selection”).

³⁴ S. REP. NO. 101-116, at 84 (1989) (emphasis added).

ADA protections have been further weakened by appellate courts' construction of the "insurance safe harbor" provision, requiring evidence of specific intent to discriminate rather than the mere absence of actuarial or other objective data to support the distinctions.³⁵ Judicial interpretations of the ADA's insurance provision have generally allowed insurance plans to deny and place caps on care for a range of health conditions so long as all policyholders receive the same package of health benefits.³⁶

Most important for purposes of the Parity Act, the ADA has been consistently interpreted to permit health plans to offer more limited benefit coverage for mental health and substance use disorders than for physical conditions. Two grounds for allowing this inferior coverage in health insurance have been articulated. First, according to the EEOC, "nervous/mental" conditions do not meet the threshold ADA requirement of being a "disability-based" distinction because they apply to a "multitude of dissimilar conditions and . . . constrain individuals both with and without disabilities."³⁷ Second, because these benefits apply

³⁵ See, e.g., *Leonard F. v. Israel Disc. Bank of N.Y.*, 199 F.3d 99, 104-06 (2d Cir. 1999); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612 (3d Cir. 1998) (refusing to require insurance companies to justify their insurance coverage; subterfuge analysis would elevate courts to position of "super-actuary" and "watchdog" of insurance business); John V. Jacobi, *Parity and Difference: The Value of Parity Legislation for the Seriously Mentally Ill*, 29 AM. J.L. & MED. 185, 188-89 (2003) (stating that narrow interpretations of the ADA safe harbor provision will result in no protection against discriminatory treatment in insurance coverage of persons with mental illness).

³⁶ See, e.g., *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 563 (7th Cir. 1999) (refusing to strike limits on medical coverage for AIDS as Title III does not require insurance product to be "equally valuable to the disabled and the nondisabled"); *Lenox v. Healthwise of Ky., Inc.*, 149 F.3d 453, 457-58 (6th Cir. 1998) (holding that a health insurance plan that covered some but not all organ transplants did not violate Title I, II, or III, because the same policy was provided to all employees, and the ADA does not mandate equality between individuals with different disabilities); *Modderno v. King*, 82 F.3d 1059, 1066 (D.C. Cir. 1996) (Ginsburg, J., concurring) (opining that a monetary cap on hospitalization for mental illness was not a violation of the Rehabilitation Act because same insurance coverage was made available to all regardless of handicap; "[e]qual coverage for all is non-discriminatory").

³⁷ EEOC, *supra* note 32; see also *Modderno*, 82 F.3d at 1061 (holding that a lifetime cap on mental health benefits that did not distinguish between disabling and non-disabling mental illness did not meet disability-based criteria). Clearly, health insurance plans cover "health conditions," and an individual who seeks to challenge a restrictive mental health or substance use disorder benefit under the ADA would have to establish a "substantial limitation on a major life activity," to meet the ADA coverage standard. See 42 U.S.C.A. § 12102 (Westlaw 2012). At the same time, the EEOC's pronouncement that "nervous/mental" conditions are not a disability-based classification seems inconsistent with the types of classifications it found would be covered, i.e., an insurance term or provision that "singles out a particular disability . . . , a discrete group of disabilities (e.g., cancers, muscular dystrophies, kidney diseases), or disability in general." EEOC, *supra* note 32. Mental illness and addiction are certainly a discrete group of disabilities for those individuals who can meet the definition of disability, and these conditions are no different than the referenced health conditions that would also encompass persons with and without disabilities. Under the ADA Amendments Act of 2008, a plaintiff could satisfy the definition of "disability" fairly easily, as

“equally” to all plan participants, courts conclude that the plans are not engaged in intentional discrimination on the basis of disability—the requisite standard for finding insurance discrimination under the ADA.³⁸

Although a more restrictive mental health benefit will have a greater impact on individuals with a mental health disability as compared to the general public or those with physical disabilities, a claim alleging a disparate impact in health benefits is not generally actionable under the ADA.³⁹ Courts that have considered the validity of more restrictive mental health coverage for persons in disability insurance policies—those in which disability is explicitly the basis for coverage—have generally upheld differential standards for mental illness as long as persons with mental disabilities are not provided different benefit coverage than persons without disabilities.⁴⁰ Recently, some courts have applied a more expansive definition of disability discrimination based on the Supreme Court’s decision in *L.C. v. Olmstead*,⁴¹ which recognizes that discrimination between classes of disabled persons is actionable. This has allowed courts to reach the merits of disability insurance policies (as opposed to health insurance plans) that offer more restrictive

mental health and substance use disorders are impairments that substantially limit the brain and neurological system. 42 U.S.C.A. § 12102(2)(B), (4)(E)(i) (Westlaw 2012). However, meeting this threshold would not necessarily result in success on an insurance discrimination claim, given the required proof of disparate treatment as opposed to disparate impact.

³⁸ EEOC, *supra* note 32 (relying on *Alexander v. Choate*, 469 U.S. 287 (1985), for the proposition that disparate-impact discrimination is not a basis for insurance benefit design challenges); *see also Modderno*, 82 F.3d at 1065 (finding that a lifetime maximum of \$75,000 for mental health benefits under federal benefit plan did not violate Section 504, because the plan did not use a disability-based criterion in setting the limitation, and, while the standard would have an unequal impact on persons with mental illness as compared to those with physical disabilities, Section 504 did not reach disparate-impact claims under *Alexander v. Choate*); *Doe v. Colautti*, 592 F.2d 704,708-09 (3d Cir. 1979) (holding that a limit on the number of days covered by state Medicaid in private psychiatric hospital as compared to unlimited duration of care in general private hospital did not violate Section 504 of the Rehabilitation Act, because the Act only requires coverage for persons with mental illness that is equal to that provided to persons without disabilities and does not require provision of specialized services for persons with disabilities).

³⁹ Although the Supreme Court in *Alexander v. Choate* did not, in fact, rule out disparate-impact claims in the context of health insurance, its ruling would require that the disparity between persons with and without disabilities be so substantial as to effectively deny persons with disabilities meaningful access to coverage. *Alexander*, 469 U.S. at 301, 303 (“Section 504 does not require the State to alter . . . the benefit being offered simply to meet the reality that the handicapped have greater medical needs.”); *see Modderno*, 82 F.3d at 1066 (Ginsburg, J., concurring) (explaining the ruling in *Alexander*). Access to some coverage, albeit inferior, would not satisfy this standard.

⁴⁰ *See EEOC v. Staten Island Sav. Bank*, 207 F.3d 144, 149 (2d Cir. 2000); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116-17 (9th Cir. 2000); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10th Cir. 1999); *Lewis v. Kmart Corp.*, 180 F.3d 166, 170 (4th Cir. 1999); *Rogers v. Dep’t of Health & Envtl. Control*, 174 F.3d 431, 434 (4th Cir. 1999); *Ford v. Shering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1015 (6th Cir. 1997) (en banc).

⁴¹ *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

mental disability coverage than physical disability coverage.⁴² These cases suggest that the ADA would invalidate disparate disability insurance coverage for mental health/substance use disorders if the plan was motivated by stereotypes about mental disability rather than by actuarial considerations.⁴³

This more expansive concept of discrimination, while never applied in health insurance cases brought under the ADA or Rehabilitation Act, is the foundation of the Parity Act's non-discrimination standards. Congress started with the principle that disparate insurance standards between mental health/substance use disorders and physical conditions are deemed to be discriminatory, unless clinical justifications, not *actuarial* reasons, support a different standard.

What led Congress to regulate health insurance standards for persons with mental health and substance use disorders and provide unique discrimination protections that are not available to persons under the ADA and Rehabilitation Act?⁴⁴ To answer this question, the following two sections briefly describe the evolution of the managed behavioral health care system for mental health and substance use disorders and the impact of that system on service delivery and access to insurance-reimbursed services. In brief, a pattern of “wrongful” discrimination⁴⁵ had emerged that compelled Congress to enact the

⁴² See *Fletcher v. Tufts Univ.*, 367 F. Supp. 2d 99, 110-11 (D. Mass. 2005) (denying motion to dismiss ADA claims because the disparate treatment of persons with mental and physical illness in long-term disability insurance plan may reflect a view of persons with mental illness that is based on stereotype rather than assessment of severity of condition); *Iwata v. Intel Corp.*, 349 F. Supp. 2d 135, 155 (D. Mass. 2004) (denying motion to dismiss ADA claim of unlawful differential treatment under employer's long-term disability coverage for mental illness, because the widespread practice of limiting disability benefits may be “based on assumptions that mental illness is ‘less real’ than physical disability, or that recovery therefrom is more a matter of will than in the case of physical disability” and in light of the absence of actuarial data to support the disparate standard). A panel of the Eleventh Circuit articulated this same notion of discrimination when evaluating disparate mental illness coverage under a disability insurance policy. See *Johnson v. K Mart Corp.*, 273 F.3d 1035, 1054 (11th Cir. 2001), *vacated for reh'g en banc*, 281 F.3d 1368 (11th Cir. 2002) (per curiam) (abstaining from rendering a decision pending bankruptcy proceedings). The EEOC endorsed this broader interpretation of disability-based discrimination in an amicus curiae brief filed in *Johnson*. *Id.* at 1051.

⁴³ *Fletcher*, 367 F. Supp. 2d at 111 (“If the LTD Plan’s distinction between classes of persons with disabilities is based on such stereotypes or is otherwise arbitrary, Title I, considered in the light of *Olmstead*, would condemn the Plan as applied to *Fletcher*.”); *Iwata*, 349 F. Supp. 2d at 155.

⁴⁴ See *Moderno*, 82 F.3d at 1062 (finding that the Rehabilitation Act does not afford such special protection).

⁴⁵ DEBORAH HELLMAN, *supra* note 24, at 13. Professor Hellman has explored the question of when it is permissible for public and private entities to draw distinctions among people and when such line drawing constitutes “wrongful” discrimination. Distinctions drawn by an insurer may cross the line into “wrongful” discrimination if, according to Hellman, the insurer’s policy expresses denigration of or demeans a group of individuals based on “our common history and culture and its

Parity Act. At the same time, Congress's rejection of the prevailing discriminatory insurance standards was incomplete, as the bill's sponsors had to balance powerful insurance industry and consumer interests to achieve passage. Specific legislative compromises, described in subpart B of this Part, facilitated the enactment of significant, yet imperfect, non-discrimination protections. Those "compromise provisions" have contributed to uncertainty in interpretation that ultimately undermines current enforcement efforts.

2. *Controlling the Cost of Mental Health and Addiction Treatment*

Insurance carriers point to both actuarial data and unique features in mental health and substance use disorder care to justify separate and distinct insurance standards. First, evidence related to "moral hazard"⁴⁶ suggests that consumer demand for mental health care is more elastic based on price than the corresponding demand for care for other conditions. In studies conducted during the 1970s and 1980s, the reported consumer response to reduced cost-sharing in mental health care was nearly twice as large as the response in medical services.⁴⁷ This data justified insurers' choice to "regulate" consumer utilization by imposing

conventions and social understandings." *Id.* at 35. Discriminatory insurance standards for persons with mental health and substance use disorders continue to express the view that individuals with alcohol and drug addiction and mental illness are less worthy of equal treatment than other individuals, consistent with our history of segregating and institutionalizing persons with these disorders. See RICHARD G. FRANK & SHERRY A. GLIED, *BETTER BUT NOT WELL: MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950*, at 1-2 (2006); see generally DAVID MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTICS CONTROL*, at 273-93 (3d ed. 1999).

⁴⁶ "Moral hazard" refers to the increase in use and costs that result from the provision of insurance coverage and applies to all forms of health and other insurance. Richard G. Frank et al., *Will Parity in Coverage Result in Better Mental Health Care?*, 345 *NEW ENG. J. MED.* 1701, 1701 (2001); see also Deborah A. Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, 6 *CONN. INS. L.J.* 11, 13-15, 45 (1999) (describing "moral hazard" as the economics, as opposed to political science, paradigm for analyzing insurance). Professor Stone objects to the conventional construction of "moral hazard," which ascribes "immoral" motives to persons who seek insurance and justifies limitations on the conditions and level of coverage and the kinds of persons and risks that will be insured. *Id.* at 13-15. She posits a paradigm of insurance as a "major way that communities can make life better for their individual members" and collective well-being. *Id.* at 15.

⁴⁷ Frank et al., *supra* note 10, at 110. The most widely cited study for the moral hazard problem in mental health care is the RAND Health Insurance Experiment, conducted in the mid-1970s, which found that ambulatory medical expenses double when going from no insurance to full insurance, while ambulatory mental health expenditures quadruple. *Id.* at 110; see also Vanessa Azzone et al., *Effect of Insurance Parity on Substance Abuse Treatment*, 62 *HEALTH AFF.* 129, 132-33 (2011) (suggesting that substance use treatment is less price-sensitive than mental health treatment); Colleen L. Barry et al., *The Costs of Mental Health Parity: Still an Impediment?*, 25 *HEALTH AFF.* 623, 625-29 (2006) (outlining five studies evaluating demand-response for mental health treatment).

higher costs on consumers of certain mental health services.⁴⁸ Insurers also cite adverse selection risk⁴⁹ that results when plans offer more generous mental health benefits and, consequently, attract persons with chronic mental health problems who anticipate the need for substantial care. Such plans must reimburse for higher expenditures, face the prospect of increasing premiums to support higher costs, and potentially experience the loss of healthier plan members who seek less costly insurance.⁵⁰ To preserve profitability, plans limit their mental health benefits to avoid the risks posed by persons with mental health illness.⁵¹

At the behest of employers, insurance carriers and self-insured group health plans responded to both the moral hazard and adverse-selection problems, and the growth in mental health spending in the 1980s,⁵² by adopting design features to tightly control access to and utilization of mental health services. Plans imposed tight limitations on the number of outpatient visits or days of inpatient care that would be authorized and reimbursed, and they increased cost-sharing requirements to control consumer demand.⁵³ Many insurance carriers also adopted managed care standards, such as utilization review and prior or concurrent authorization protocols, to control service supply. In addition to these traditional tools, insurers began to “carve out” the delivery of addiction and mental health services from medical services and turn the

⁴⁸ Barry et al., *supra* note 47, at 627.

⁴⁹ See Frank et al., *supra* note 10, at 111. (“Adverse selection occurs when potential enrollees differ in their risks, know more about their health risks than do health plans, and enroll in health plans that are paid premiums that do not fully reflect those differences in risks.”).

⁵⁰ *Id.* (describing an Aetna plan offered in the FEHB program in the 1970s that provided a mental health parity benefit not offered by Blue Cross; Aetna attracted a “needier” population of enrollees, lost money, and rescinded its benefit); see also *Doe v. Devine*, 703 F.2d 1319, 1325, 1331 (D.C. Cir. 1983) (allowing reduction in mental health benefits in FEHBP plan offered by Blue Cross/Blue Shield, noting purpose of benefit reduction was to avoid adverse selection).

⁵¹ Frank et al., *supra* note 10, at 111.

⁵² FRANK & GLIED, *supra* note 45, at 87-88. Estimates of spending on substance use disorder services are often combined with those for mental health services, because of the high rate of co-occurring disorders among patients and the practice of coding a service as a mental health service rather than substance use disorder, to ensure reimbursement. KATHARINE R. LEVIT ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., PROJECTIONS OF NATIONAL EXPENDITURES FOR MENTAL HEALTH SERVS. AND SUBSTANCE ABUSE TREATMENT 2004-2014, at 13, 28 (2008), available at www.samhsa.gov/Financing/file.axd?file=2009%2F6%2FProjections+of+National+Expenditures+for+Mental+Health+Services+and+Substance+Abuse+Treatment%2C+2004-2014.pdf. Nonetheless, spending for substance use disorder services has historically accounted for a very small portion of total mental health spending. In 1986, 22% of total mental health spending was for substance use disorder services, and by 2003 it had dropped to 17%. *Id.* at 28.

⁵³ Barry et al., *supra* note 47, at 627. By 1995, 89% of private insurance plans had inpatient limits on mental health benefits and 96% had limits on outpatient care. *Id.* According to Barry and her colleagues, day limitations, when coupled with sizable cost-sharing, are intended to risk-select, rather than protect against higher than average utilization, because a day limit offers only modest savings when cost-sharing is imposed. *Id.*

management of those benefits over to separate managed behavioral health organizations (MBHOs).⁵⁴ MBHOs developed tight networks of participating providers that agreed to reduced rates in exchange for a higher volume of patients directed to the network providers,⁵⁵ and they limited access to care outside of those networks. MBHOs also adopted algorithms related to standard length of treatment⁵⁶ and adopted strict medical management protocols for the preauthorization of hospital and office visits.⁵⁷

Each of these strategies had the goal of controlling costs.⁵⁸ Professors Richard Frank and Sherry Glied,⁵⁹ who have chronicled the history of mental health care in the United States, observed that MBHO practices have restricted choice, but suggested, based on data up to the year 2000, that these restrictions were offset by substantial savings for consumers. As of 2000, consumers paid less for many key mental health services than they had paid in the late 1980s.⁶⁰

⁵⁴ FRANK & GLIED, *supra* note 45, at 88 (large-scale introduction of managed behavioral health care carve-out industry began in 1987, and MBHOs dominated the field by 1994).

⁵⁵ *Id.* According to Frank and Glied, MBHOs recognized that a range of professionals, including master-level social workers and psychologists, could provide certain mental health care as effectively as psychiatrists and Ph.D. psychologists, and MBHOs could reduce the cost of care while making it more available to the public by directing patients to those network providers. As a result, earnings for psychiatrists and psychologists declined during the 1990s while the earnings of social workers remained constant, and overall earnings of master-level professionals converged at the level of social workers. *Id.* at 87-88.

⁵⁶ Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5422 (Feb. 2, 2010) (referring to MBHOs as “vendors” that are known as “behavioral health carve-outs” that use various tools to control spending for mental health and substance use treatment); *see also* Letter from Justine Handelman, Exec. Dir. Blue Cross Blue Shield Ass’n, to Timothy Geithner, U.S. Treasury Sec’y, Kathleen Sebelius, U.S. Health & Human Servs. Sec’y, and Hilda Solis, U.S. Labor Sec’y 9 (May 3, 2010), *available at* www.dol.gov/ebsa/pdf/1210-AB30-5371.pdf (comments on the Interim Final Rules implementing the Parity Act) (noting the behavioral health literature indicates that the average number of visits to a non-physician provider for treatment of a mental health/substance use disorder is approximately six visits; if a patient has substantially more visits, “there may be a need to manage the benefit”).

⁵⁷ FRANK & GLIED, *supra* note 45, at 88. Implementing prior authorizations for psychiatric admissions rapidly reduced hospital admission rates, caused a real decline in occupancy rates, and consequently gave MBHOs increased bargaining power over cost with hospitals that were eager to maintain occupancy. *Id.*

⁵⁸ Carter & Landau, *supra* note 1, at 46-47 (“[Behavioral health management (BHM)]companies are generally considered to be conservative with their determinations of medical necessity, especially for hospitalization. Providers have generally accepted these strict BHM determinations consistent with a long history of employer plans providing a second-class level of benefits for mental health services.”).

⁵⁹ As the Deputy Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services from 2009-2011, Professor Frank was directly involved in the development of the Parity Act regulations. Professor Glied has served as the Assistant Secretary for Planning and Evaluation at the Department from July 2010 and is involved in the enforcement of the law.

⁶⁰ FRANK & GLIED, *supra* note 45, at 90.

MBHOs, insurance carriers, and business associations defend these arrangements as necessary to ensure quality care and good patient management in the most appropriate setting.⁶¹ According to insurers, extensive and different oversight is needed because diagnosis and treatment protocols for mental health and substance use disorders are less “objective”⁶² and allow for greater practitioner discretion⁶³ than standards for medical services, which often follow standardized treatment protocols.⁶⁴ An insurer knows, for example, when a broken leg is mended, because an x-ray provides visual evidence of healing, but bright-line indicators for the termination of mental health and substance abuse treatment do not exist.⁶⁵ Close monitoring in the form of prior authorization and frequent concurrent review permits an insurer to identify patients who are not improving, require different interventions,⁶⁶ or no longer meet medical necessity criteria.⁶⁷ Insurers also point to the

⁶¹ These explanations are taken, in part, from comments submitted by these same entities on the parity Interim Final Rule, which subjects medical management tools to scrutiny. Insurers and business associations opposed the potential disruption of these practices, which they acknowledged are not comparable to management practices for general medical/surgical care. *See, e.g.*, Letter from Paul M. Rosenberg, General Counsel, ValueOptions, Inc., to Office of Health Plan Standards & Compliance Assistance Emp. Benefits Sec. Admin., U.S. Dep’t of Health & Human Servs., and Internal Revenue Serv. 6-7 (May 3, 2010), *available at* www.dol.gov/ebsa/pdf/1210-AB30-5373.pdf (comments on the Interim Final Rules implementing the Parity Act); Letter from Kathryn Wilber, Am. Benefits Council, Neil Trautwein, National Retail Fed’n, and Randel K. Johnson, U.S. Chamber of Commerce, to U.S. Dep’t of Labor 5-6 (May 28, 2009), *available at* www.dol.gov/ebsa/pdf/1210-AB30-5365.pdf (comments on the Parity Act Interim Final Regulations).

⁶² *See* Letter from Anthony M. Kotin, Chief Medical Officer, Magellan Health Servs., to the Emp. Benefits Sec. Admin., Dep’t of Health & Human Servs., and U.S. Dep’t of Treasury 24 (May 3, 2010), *available at* www.dol.gov/ebsa/pdf/1210-AB30-5358.pdf (comments on the Interim Final Rules implementing the Parity Act) (observing that patients may stay in treatment unnecessarily because of “loneliness, personal development issues and other reasons unrelated to medical necessity”); SARA ROSENBAUM ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., MEDICAL NECESSITY IN PRIVATE HEALTH PLANS: IMPLICATIONS FOR BEHAVIORAL HEALTH CARE 14 (2003), *available at* store.samhsa.gov/shin/content/SMA03-3790/SMA03-3790.pdf.

⁶³ Letter from Paul M. Rosenberg, *supra* note 61, at 7.

⁶⁴ Letter from Justine Handelman, *supra* note 56, at 10.

⁶⁵ Letter from Madeleine Steckel, Assoc. Regulatory Counsel, Magellan Health Servs., to U.S. Dep’t of Labor 7 (May 28, 2009) (request for information regarding the Parity Act). Cenpatico, another MBHO, identified similar differences even with the care of chronic medical conditions, such as diabetes, as opposed to acute conditions. It noted that medical management of diabetes involves laboratory work and office visits as compared to extensive psychotherapy for mental health conditions like depression. Letter from Sam Donaldson, President & CEO, Cenpatico 3 (May 3, 2010), *available at* www.dol.gov/ebsa/pdf/1210-AB30-5324.pdf (comments on the Interim Final Rules implementing the Parity Act).

⁶⁶ *See* Letter from Justine Handelman *supra* note 56, at 8-9.

⁶⁷ One MBHO noted that patients seek to continue behavioral health care long after treatment has returned them to normal levels of functioning, defining this as elective care that is not common for medical/surgical care. Letter from Patricia L. Friedley, Exec. Vice President, Behavioral Health Sys., to Dep’t of Health & Human Servs. 2 (May 3, 2009), *available at* www.dol.gov/ebsa/pdf/1210-AB30-5337.pdf (comments on the Interim Final Rules implementing the Parity Act). This same

diversity of the behavioral health workforce—a feature MHBOs capitalized on to lower costs—as another feature warranting special oversight. Medical care is typically delivered by licensed providers and in licensed medical facilities, while behavioral health care is provided by a broader range of practitioners—psychiatrists, psychologists, licensed social workers, certified addiction counselors, and lay peer support—who have varying degrees of education, training, and licensure, as well as different approaches to care and recovery.⁶⁸ One leading MHBO has asserted that its clients rely on it to conduct specialized credentialing to assure high quality care.⁶⁹

Parsing the merits of the insurance industry’s assertions is less important (for now)⁷⁰ than understanding the significant impact these distinctive practices have had on the financing of and access to privately insured mental health and substance use care over the past twenty years. Although Professors Frank and Glied found that, in the early period of MHBO activity “reductions in spending and costs [did] not come at the expense of the quality of care,”⁷¹ their review of mental health treatment data from 1996 to 2006 identified several disturbing trends.⁷² Evidence of human suffering and increased health and social costs related to untreated addiction and mental health motivated Congress to take corrective action.

3. *Impact of Managed Behavioral Health Care on Health Services Delivery*

The effect of MBHO medical management practices on behavioral health care services is readily apparent from the decline in funding for substance use disorder treatment. In 1986, private insurance accounted for 30% of funding for substance use disorder treatment.⁷³ By 2003, private insurance paid for only 10% of substance use treatment,⁷⁴ and

MBHO imposed health benefit conditions on patients in substance use disorder treatment to reduce “recidivism.” *Id.* at 3.

⁶⁸ ROSENBAUM ET AL., *supra* note 62, at 14-15.

⁶⁹ Letter from Anthony M. Kotin, *supra* note 62, at 28.

⁷⁰ See discussion *infra* accompanying notes 294-298.

⁷¹ FRANK & GLIED, *supra* note 45, at 89.

⁷² Sherry A. Glied & Richard G. Frank, *Better but Not Best: Recent Trends in the Well-Being of the Mentally Ill*, 28 HEALTH AFF. 637, 646 (2009).

⁷³ LEVIT ET AL., *supra* note 52, at 32.

⁷⁴ *Id.* Researchers attributed this “almost nonexistent” growth in private insurance spending for substance use disorder treatment to the “evolution of managed care and the cost-containment efforts of businesses.” *Id.* at iv. They likewise projected slow acceleration in the future. *Id.*

public financing constituted more than three fourths of all spending.⁷⁵ This funding imbalance is in sharp contrast with spending for all other health care, where public sources pay for less than half of the care.⁷⁶ This funding pattern,⁷⁷ according to researchers, is directly related to barriers in insurance coverage for substance use treatment that do not exist for medical services.⁷⁸ Specialty substance abuse treatment centers, largely publicly funded, now rank the highest among service providers based on spending.⁷⁹ This abdication by private health insurers contributes to an alarmingly large number of persons who receive no treatment for their substance use conditions. Only 11% (2.3 million individuals) of the nearly 21.6 million individuals who needed treatment for an alcohol or drug use disorder in 2011 received care at a specialty treatment facility.⁸⁰

A slightly different picture emerges for mental health spending, but one nonetheless shaped by managed behavioral health care. Private insurance funding for mental health care increased slightly from 1986 to 2003—from 21% to 24%⁸¹—primarily as a result of the significant increase in the use of prescription medications for mental health disorders⁸² and increased access to care through primary care physicians who have gained comfort in prescribing these medications.⁸³ MBHO

⁷⁵ *Id.*; Katharine R. Levit et al., *Future Funding for Mental Health and Substance Abuse: Increasing Burdens for the Public Sector*, 27 HEALTH AFF. w513 (2008).

⁷⁶ *Id.* at w516; Buck, *supra* note 19, at 1403.

⁷⁷ Projections of financing for substance use disorder treatment made prior to the enactment of the Parity Act estimated that by 2014 private insurance coverage would drop to 7% of all costs, and public insurance would increase to cover 83% of costs. Levit et al., *supra* note 75, at w520.

⁷⁸ *Id.* at w520-w521 (differential standards include annual and lifetime limits for inpatient hospitalization and outpatient visits and higher cost-sharing through deductibles and coinsurance).

⁷⁹ *Id.* at w519, w520-w521 (41% of services in 2003, up from 19% in 1986).

⁸⁰ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2011 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 84 (2012). Specialty treatment is defined as treatment received at a hospital (inpatient only), drug or alcohol rehabilitation facility (inpatient or outpatient), or mental health center. *Id.* at 83. An additional 1.2 million individuals received care for their substance use conditions at private doctors' offices or emergency rooms. *Id.* at 81. Among the roughly one million individuals who perceived a need for treatment but did not receive care, one-third (32.3%) reported that they had no health coverage and could not afford the cost. *Id.* at 86.

⁸¹ Levit et al., *supra* note 75, at w517 (exhibit 3).

⁸² Richard G. Frank et al., *Trends in Mental Health Cost Growth: An Expanded Role for Management*, 28 HEALTH AFF. 649, 657 (2009) (spending on medications increased from 7% in 1986 to 23% in 2003, a trend directly related to the costs of prescription drugs being handled outside the typical MBHO carve-out plan).

⁸³ Levit et al., *supra* note 75, at w518. Since cost-sharing is generally lower for primary care physician visits than for specialty mental health care, patients have been encouraged to seek care in their general medical setting. Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5423 (Feb. 2, 2010). The quality of care, however, is not necessarily as good as that provided in specialty mental health settings. One study that found 12.7%

control over costly inpatient care is readily observed in the spending reductions for specialty mental health hospitals and nursing homes.⁸⁴ The private sector lost 30,000 psychiatric hospital beds from 1990 to 2002 as a result of managed care utilization review and economic factors.⁸⁵

Professors Frank and Glied have also identified several other trends in mental health care provided from 2000 to 2006 that reveal the “service limiting” effect of managed behavioral health care. First, the expansion of treatment through primary care practitioners has focused on populations with less serious mental health-related problems.⁸⁶ Second, the rate of psychiatric hospitalization of adults and children has increased since 2000,⁸⁷ resulting in a shortage of psychiatric beds in over three fourths of the states,⁸⁸ and persons with mental illness have faced massive incarceration.⁸⁹ Frank and Glied explain the increase in psychiatric hospitalization as either reflecting a lack of community-based services or a “return to a more balanced mix of treatment modalities”⁹⁰ following sharp reductions of admissions under strict utilization review standards. Other experts link the hospitalization and incarceration trends to other common managed care practices: short, but repeated, hospitalization that results from MBHOs applying the narrowest definition of “medical necessity” to address acute dangerousness or crisis stabilization, as opposed to longer treatments that could “prevent rapid readmission, homelessness, and criminalization.”⁹¹

of patients received minimally adequate mental health care in general medical settings compared to 48.3% of patients treated in specialty mental health settings. *Id.* (citing P.S. Wang et al., *Twelve Month Use of Mental Health Services in the United States*, 62 ARCHIVES GEN. PSYCHIATRY 629 (2005)).

⁸⁴ Levit et al., *supra* note 75, at w517 (spending for specialty mental hospitals dropped from 25% in 1986 to 12% in 2003, and for nursing homes from 14% to 6%). The portion of funding for general hospital care for mental health services (as opposed to specialty hospitals) did not drop during this period; 17% of care in 1986 and 16% of care in 2003 was provided in general hospital psychiatric units. *Id.* This contrasts with addiction care, in which all hospital-based services declined. *Id.* at w520.

⁸⁵ Steven S. Sharfstein & Faith B. Dickerson, *Hospital Psychiatry for the Twenty-First Century*, 28 HEALTH AFF. 685, 686 (2009).

⁸⁶ Glied & Frank, *supra* note 72, at 646. Persons with “mental health activity limitations” reported having less contact with mental health professionals, and senior citizens reported a steeper decline in professional mental health services. *Id.* at 640.

⁸⁷ *Id.* at 642; Sharfstein & Dickerson, *supra* note 85, at 686.

⁸⁸ Sharfstein & Dickerson, *supra* note 85, at 686.

⁸⁹ Glied & Frank, *supra* note 72, at 645-46.

⁹⁰ *Id.* at 646.

⁹¹ *Id.*; Sharfstein & Dickerson, *supra* note 85, at 687.

4. *The People Behind the Numbers*

Stories of real human suffering demonstrate the harsh consequences of limiting mental health and substance use disorder services. In congressional field hearings conducted in 2008 on the parity bill, members of Congress heard stories of young lives cut short because a son or daughter could not access treatment he or she needed through a parent's insurance plan.⁹² They learned that families had paid high insurance premiums expecting to have coverage for mental health or addiction care only to find that, when care was needed, the plan's coverage was "hollow."⁹³ Provider networks did not include professionals who could treat certain mental health conditions, forcing families to seek care from more expensive out-of-network providers;⁹⁴ insurance companies suspended payment for residential addiction treatment after several days of care⁹⁵ and doled out authorizations for care for only two or three days at a time;⁹⁶ and plans did not provide full coverage for mental health counseling and medication.⁹⁷ Ordinary citizens who testified at the hearings made the case that care for mental health and addiction disorders was limited or denied⁹⁸ in order to "save" insurance companies money to reimburse for the treatment of other medical conditions,⁹⁹ an inequity that certainly would not be tolerated if

⁹² REPRESENTATIVES PATRICK J. KENNEDY & JIM RAMSTAD, ENDING INSURANCE DISCRIMINATION: FAIRNESS AND EQUALITY FOR AMERICANS WITH MENTAL HEALTH AND ADDICTIVE DISORDERS 13 (May 2, 2007). Indeed, some commentators have attributed the inclusion of addiction services in the parity bill to the willingness of Representatives Patrick Kennedy and James Ramstad to publicly disclose their own need for treatment for prescription drug dependence and alcoholism, respectively. Barry et al., *supra* note 4, at 415-16. The Senate sponsors of the original parity bill, the late Senator Paul Wellstone and Senator Pete Domenici, had equally personal experiences with family members who suffered from mental illness. *Id.* at 416. Those involved in the legislative process concluded that "the personal dimension of this policy issue was widely viewed . . . as having been decisive." *Id.* at 417; see also Patrick J. Kennedy, *Why We Must End Insurance Discrimination Against Mental Health Care*, 41 HARV. J. ON LEGIS. 363, 364 (2004) (describing his decision to keep his depression private as typical of "millions [who] must hide debilitating diseases for fear of prejudice, where potentially life-saving healthcare is routinely denied to a disfavored class").

⁹³ See KENNEDY & RAMSTAD, *supra* note 92, at 6.

⁹⁴ *Id.* at 15.

⁹⁵ *Id.* at 14.

⁹⁶ *Id.* at 14-15.

⁹⁷ *Id.* at 13.

⁹⁸ A survey conducted by the Kaiser Family Foundation/Health Research and Education Trust in 2002 found that 74% of workers in employer-sponsored health plans with mental health benefits were subject to an annual outpatient visit limit, 64% were subject to an inpatient day visit limit and 22% had higher cost-sharing for mental health benefits than for general medical benefits. Colleen L. Barry et al., *Design of Mental Health Insurance Coverage: Still Unequal After All These Years*, 22 HEALTH AFF. 127, 129 (Sept./Oct. 2003).

⁹⁹ KENNEDY & RAMSTAD, *supra* note 92, at 18.

savings were to be achieved through reductions in care for persons with hypertension who, for example, could not maintain a healthy diet or exercise regimen.¹⁰⁰

This second-class status experienced by fully insured families¹⁰¹ is at odds with solid scientific evidence that has largely erased the line between diseases of the body and mind.¹⁰² Brain-imaging now documents the differences between a healthy and diseased brain and reveals the biological and chemical features that are associated with mental health and addiction disorders. Distinctions in insurance coverage for diseases of the body, such as Parkinson's disease, versus those of the mind, such as alcoholism, no longer hold up when the only difference between the two is the region of the brain that is affected by and implicated in the malady.¹⁰³

This objective evidence was further bolstered by cost data that undermined insurance carrier claims of unaffordability and uncontrollable consumption.¹⁰⁴ Evaluation of the economic impact of

¹⁰⁰ See *id.* at 18. Some families also took their grievances over inequitable coverage to court. See, e.g., *Edgar v. MVP Health Plan, Inc.*, No. 1:09-cv-700 (GLS\DRH), 2011 WL 1770303 (N.D.N.Y. May 9, 2011) (challenging refusal to reimburse for an out-of-network residential program); *Jon N. v. Blue Cross Blue Shield of Mass. Inc.*, 684 F. Supp. 2d 190 (D. Mass. 2010) (challenging refusal to reimburse for an adolescent's residential care because level of care not covered); *Hirsh v. Boeing Health & Welfare Benefit Plan*, 719 F. Supp. 2d 508 (E.D. Pa. 2010) (challenging cap on reimbursement for residential treatment); *Smith v. Blue Cross Blue Shield of Mass. Inc.*, 597 F. Supp. 2d 214 (D. Mass. 2009) (challenging denial of reimbursement for residential treatment based on restrictive medical necessity criteria of safety risk); *Slover v. Boral Henderson Clay Prods., Inc.*, 714 F. Supp. 825 (E.D. Tex. 1989) (challenging refusal to reimburse for the portion of treatment that could be designated as alcoholism or depression services as opposed to drug addiction treatment); *DePina v. Gen. Dynamics Corp.*, 674 F. Supp. 46 (D. Mass. 1987) (challenging denial of reimbursement for court-ordered alcoholism treatment).

¹⁰¹ See KENNEDY & RAMSTAD, *supra* note 92, at 6.

¹⁰² See A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 J. AM. MED. ASS'N 1689, 1691 (2000) (describing pathophysiologic changes in the brain from alcohol and drug use); Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions*, 68 U. COLO. L. REV. 63, 65-67 (1997) (citing testimony of the Director of the National Institute of Mental Health in 1996 that "no biomedical justification [exists] for differentiating serious mental illness from other serious and potentially chronic disorders of the nervous system such as stroke, brain tumor, or paralysis"). Some may argue that individuals with alcohol and drug dependence are responsible for the initial use of alcohol or drugs that resulted in their condition. The volitional feature of this condition is, according to experts, not significantly different from many other chronic health conditions, such as hypertension and diabetes, that have a strong genetic contribution and for which an individual's choices related to diet, exercise, and stress control will affect whether he or she develops the condition or exacerbates it through noncompliance with treatment. McLellan, *supra*, at 1690, 1693.

¹⁰³ KENNEDY & RAMSTAD, *supra* note 92, at 9.

¹⁰⁴ *Id.* at 19-21; see also Barry et al., *supra* note 4, at 409-15 (outlining the history of Congressional Budget Office (CBO) scoring the cost of parity and conflicting actuarial estimates that doomed early parity legislation; concluding that academic research on the costs of parity under a

state parity laws and the Federal Employee Health Benefit Program (FEHBP) parity requirements¹⁰⁵ demonstrated that spending does not increase measurably when coverage is provided under a managed care system.¹⁰⁶ The single significant economic effect has been improved financial security for consumers who have lower out-of-pocket costs.¹⁰⁷ On the flip side, the overwhelming cost of untreated addiction and mental health disorders convinced some employers and insurers that

managed care system resulted in a favorable Congressional Budget Office (CBO) score and changed perceptions in Congress that comprehensive parity would not “break the bank”); H.R. REP. NO. 110-374(I) at 39-44 (2008) (CBO cost estimate of the House-passed parity bill, H.R. 1424).

¹⁰⁵ The FEHBP parity standard, as implemented in 2001, required plans to cover all categories of mental health and substance use disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) to the extent authorized in a treatment plan, and it regulated all aspects of in-network benefits—including cost-sharing, deductibles, lifetime and annual dollar limits, and day and visit limitations—requiring identical levels of coverage. U.S. Office of Pers. Mgmt., FEHB Program Carrier Letter, No. 2000-17, 2-4 (Apr. 11, 2000), *available at* fehb.opm.gov/carrier/carrier_letters/2000/2000-17.pdf. The Office of Personnel Management (OPM) required benefit levels for mental health/substance use disorders to be comparable to medical treatment based on the category of care (e.g., inpatient hospital, specialist office visits, diagnostic tests, and pharmacy benefits) and encouraged a continuum of services, including partial hospitalization and intensive outpatient care. *Id.* at 3-4. OPM also encouraged the use of a range of benefit management techniques to “mitigate the cost impact” of expanding access to services, including the use of a MBHO to establish provider networks and manage services. *Id.* at 3; *see generally* Colleen L. Barry & M. Susan Ridgley, *Mental Health and Substance Abuse Insurance Parity for Federal Employees: How Did Health Plans Respond?*, 27 J. POL’Y ANALYSIS & MGMT. 155 (2008) (describing the parity standards and FEHB plan development in response to the parity standards). Following the enactment of the Parity Act, OPM extended parity standards to out-of-network providers, U.S. Office of Pers. Mgmt., FEHB Program Carrier Letter, No. 2008-17, 1-2 (Nov. 10, 2008), *available at* fehb.opm.gov/carrier/carrier_letters/2008/2008-17.pdf, and continued to require coverage of all categories of mental health and substance use disorder care included in an authorized treatment plan; U.S. Office of Pers. Mgmt., FEHB Program Carrier Letter, No. 2009-08, 5 (Apr. 20, 2009), *available at* fehb.opm.gov/carrier/carrier_letters/2009/2009-08.pdf. OPM has also advised participating plans that they must comply with the Parity Act’s non-quantitative treatment limitation standards. U.S. Office of Pers. Mgmt., FEHB Program Carrier Letter, No. 2010-06, 6 (Apr. 7, 2010), *available at* www.opm.gov/healthcare-insurance/healthcare/carriers/010/2010-06.pdf.

¹⁰⁶ *See* Susan T. Azrin et al., *Impact of Full Mental Health and Substance Abuse Parity for Children in the Federal Employees Health Benefits Program*, 119 PEDIATRICS e452, e457 (2007) (reporting that spending on mental health and substance abuse services for children decreased significantly in three of seven plans and slightly decreased in the remaining four plans); Howard H. Goldman et al., *Behavioral Health Insurance Parity for Federal Employees*, 354 NEW ENG. J. MED. 1378, 1378, 1383 (2006) (reporting that plan spending on mental health and substance abuse services for adults significantly decreased in three of seven FEHBP plans as a result of parity and moderately decreased or increased for the other four plans).

¹⁰⁷ *See* Azrin et al., *supra* note 106, at e457; Sherry Glied & Alison Cuellar, *Better Behavioral Health Care Coverage for Everyone*, 354 NEW ENG. J. MED. 1415, 1416 (2006) (noting that FEHB parity led to out-of-pocket spending reductions and operated “just as insurance coverage should [by] . . . shift[ing] costs from out-of-pocket spending to the insurance company (and eventually to very small increases in insurance premiums) without leading to an increase in the use of services”); Goldman et al., *supra* note 106, at 1384 (reporting a significant reduction in out-of-pocket spending associated with implementation of parity in five of the seven FEHBP plans).

health insurance equity was too expensive *not* to provide.¹⁰⁸ Employer data confirmed that untreated mental health and substance use disorders contributed significantly to lost productivity and absenteeism in the workplace¹⁰⁹ and that limitations on behavioral healthcare services could increase employers' direct and indirect healthcare costs.¹¹⁰

In brief, health insurance standards for mental health and substance use disorders did not meet basic standards of equality and fairness and failed to reflect contemporary science and medicine. Individuals with addiction and mental health disorders were unquestionably more vulnerable to discrimination, and special legislative protection was needed to constrain the impulse of insurers to shift health costs to the individuals who suffered from those conditions, their employers, and the public health, social services, and criminal justice systems. Congress enacted parity legislation because these diverse interests convinced lawmakers that insurance expansion was, in the words of Professor Deborah Stone, a "moral opportunity."¹¹¹ Consumers, health providers, advocates, and personally invested members of Congress helped change the "cultural understanding" of addiction and mental health disorders and the role insurance should play in covering the cost of that care.¹¹² Their evidence of "inequality" challenged "the fundamental principle of actuarial fairness upon which most insurance operates."¹¹³ Congress ultimately recognized that individuals with addiction and mental health disorders deserved the same level of health and financial security provided to those who suffer from other medical conditions.¹¹⁴

¹⁰⁸ KENNEDY & RAMSTAD, *supra* note 92, at 20; Barry et al., *supra* note 4, at 418 (explaining that business and insurance groups that had historically opposed parity agreed to negotiate on a bill, in part because they had become aware of the additional medical costs associated with untreated mental disorders).

¹⁰⁹ Stephen P. Melek, *National Business Group on Health—Summary of Findings on the State of Employer-Sponsored Behavioral Health Services*, BEHAVIORAL HEALTH ADVISOR, Mar. 2007, available at publications.milliman.com/periodicals/bha/pdfs/national-business-group-health-BH03-30-07.pdf. The Parity Act Interim Final Rule describes the substantial costs associated with reduced employee productivity caused by depression (on the order of \$31 billion to \$51 billion annually) and cites research findings that mental illness causes more days of work loss and work impairment than other chronic conditions such as diabetes and lower back pain. 75 Fed. Reg. 5410, 5423 (Feb. 2, 2010).

¹¹⁰ Melek, *supra* note 109.

¹¹¹ Stone, *supra* note 46, at 29-34 (1999) (describing the political mechanisms by which insurance is expanded to cover more individuals and problems in mutual aid arrangements).

¹¹² *Id.* at 35-37 (describing how individuals and social reformers use insurance to alleviate problems).

¹¹³ *Id.* at 43.

¹¹⁴ *Id.* at 44-46 (observing that "American political culture almost defines inequality as an adverse event itself, something that must be remedied as soon as it is revealed"); see also Crossley, *supra* note 24, at 106-07 (explaining that parity legislation is motivated by the desire to protect a

B. ACHIEVING EQUITY BUT RETAINING DISPARATE STANDARDS

Congress's goal in enacting the Parity Act was to equalize insurance coverage for behavioral health and medical conditions, but Congress's remedy was not without compromise. Congress adopted two important standards that have created interpretive problems related to the reach of the Parity Act.

First, employer-based insurance plans retain the right to make the fundamental threshold choice to not provide *any* coverage for mental health or addiction treatment¹¹⁵ and also to define the conditions and services that would be offered for mental health and substance use disorders, limited only by the standards of the Parity Act itself and by state law.¹¹⁶ The House-passed parity bill would have required all large employer-based plans that offered coverage for addiction or mental health services to cover all medically necessary mental health conditions and addiction disorders listed in the Diagnostic and Statistical Manual of Mental Disorders¹¹⁷ to prevent discrimination based on diagnosis. The

historically disadvantaged group as well as the government's interest in ensuring economic costs resulting from untreated mental health are avoided through insurance coverage).

¹¹⁵ 26 U.S.C.A. § 9812(b)(1) (Westlaw 2012); 29 U.S.C.A. § 1185a(b)(1) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(b)(1) (Westlaw 2012) ("Nothing in this section shall be construed . . . as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits . . .").

¹¹⁶ 26 U.S.C.A. § 9812(b)(2), (e)(4)-(5); 29 U.S.C.A. § 1185a(b)(2), (e)(4)-(5); 42 U.S.C.A. § 300gg-26(b)(2), (e)(4)-(5). Plans that offer mental health or substance use disorder benefits are statutorily authorized to define the "terms and conditions" of the plans, which certainly would include the services provided. 26 U.S.C.A. § 9812(e)(4)-(5); 29 U.S.C.A. § 1185a(e)(4)-(5); 42 U.S.C.A. § 300gg-26(e)(4)-(5). That authority is explicitly restricted "except as provided in subsection (a)," which sets out the Parity Act's non-discrimination standard. 26 U.S.C.A. § 9812(b)(2); 29 U.S.C.A. § 1185a(b)(2); 42 U.S.C.A. § 300gg-26(b)(2). The statutory definition of mental health and substance use disorder benefits similarly authorizes plans to define the services for mental health conditions and substance use disorders, again in accordance with federal and state law. 26 U.S.C.A. § 9812(e)(4)-(5); 29 U.S.C.A. § 1185a(e)(4)-(5); 42 U.S.C.A. § 300gg-26(e)(4)-(5). See discussion *infra* accompanying notes 243-270. According to the National Conference on State Legislatures, forty-nine states and the District of Columbia currently regulate insurance coverage of substance use and/or mental health services. Nat'l Conference of State Legislatures, *State Laws Mandating or Regulating Mental Health Benefits* (Dec. 2012), www.ncsl.org/default.aspx?tabid=14352. The standards differ significantly, with laws requiring either "parity" to varying degrees, mandated minimum levels of coverage or mandatory offers of such coverage. *Id.* Federal law does not preempt state standards that provide greater protection than federal law. *Id.* In addition, the "scope of services" to be provided is also governed by federal law, i.e., the Parity Act itself and, arguably, any additional rights afforded under a robust enforcement of the ADA. See discussion *infra* accompanying notes 250-260 regarding the Parity Act's standards relating to scope of services.

¹¹⁷ H.R. 1424, 110th Cong. §§ 102(d), 103(d), 104(d) (2008). The House provision was modeled after the Federal Employee Health Benefit Program (FEHBP). See *supra* note 105. The Senate bill contained no provision that governed the scope of coverage, leaving that determination to the individual health plan. See generally S. 558, 110th Cong. § 2(b) (2007).

final bill did not include this provision, and it also permitted plans to determine which, if any, conditions would be covered.¹¹⁸ This facially discriminatory standard¹¹⁹ was mitigated by the law's preemption standard, which ensures that state laws mandating the coverage of addiction and mental health services remain in effect,¹²⁰ and by the non-discrimination standards imposed by the Parity Act itself. Early reports indicate that employers have not taken advantage of this significant loophole to reduce the types of mental health/substance use disorder diagnoses covered by plans.¹²¹ The landscape could change depending upon the standards in the final parity rule.

Second, but less clearly discriminatory, health plans retain the right to make medical management decisions that could continue to limit or

¹¹⁸ See *supra* note 116 and accompanying text. The official rationale for adopting or dropping certain provisions in the final Parity Act legislation is not available because the House- and Senate-passed versions of the bills were reconciled without a formal House-Senate conference or Conference Report. See Laurence Reich, *The Continuing Saga of Mental Health Parity: The MHPAEA Interim Final Rules*, NYU REV. EMP. BENEFITS 12-7-12-8 (2010). See Barry et al., *supra* note 4, at 418 (explaining that opponents to incorporating the FEHBP's DSM standard in the parity bill attacked that standard by directing attention to specific conditions that seemed non-medical and suggesting that inclusion would lead to unnecessary care). House sponsors ultimately conceded this issue, allowing the health plan to determine which conditions would be covered. Barry et al., *supra*, at 419.

¹¹⁹ See, e.g., *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293, 305 (3d Cir. 2007) (holding that a law that "singles out methadone clinics for different zoning procedures is facially discriminatory under the ADA and the Rehabilitation Act"); *MX Grp., Inc. v. City of Covington*, 293 F.3d 326, 345 (6th Cir. 2002) ("[B]lanket prohibition of all methadone clinics from the entire city is discriminatory on its face.").

¹²⁰ Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2007, 75 Fed. Reg. 5410, 5418 (Feb. 2, 2010) ("The preemption provisions of section 731 of ERISA and section 2723 of the PHS Act (added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the [Parity Act] requirements are not to be 'construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement' of [the Parity Act]."). This constitutes the "narrowest" of state law preemption, insofar as existing state mandates would not prevent the application of the Parity Act, although insurers may go beyond state minimums to comply with the Parity Act). *Id.* The preemption standard is only a partial remedy. Apart from wide variations in state parity laws regarding the types of benefits covered, diagnoses included, and eligible populations, these laws, under ERISA, apply only to employer plans purchased in the commercial market and not to self-insured employer plans. Indeed, this gap rendered state parity laws inadequate and provided a rationale for enactment of federal parity standards. See Barry et al., *supra* note 4, at 410-11; H.R. REP. 110-374(I), at 30-31 (2007).

¹²¹ According to a Government Accountability Office (GAO) review of the Parity Act's effect on the coverage of mental health/substance use disorders, 91% of the employer respondents (nearly 40% of those surveyed) reported that their most popular plan covered the same broad diagnoses in both the 2008 and current year plan. U.S. GOV'T ACCOUNTABILITY OFFICE, EMPLOYERS' INSURANCE COVERAGE MAINTAINED OR ENHANCED SINCE PARITY ACT, BUT EFFECT OF COVERAGE ON ENROLLEES VARIED 11-12 (2011).

deny care.¹²² Although insurers manage the services offered in other medical contexts,¹²³ and could not be prevented from doing so in the behavioral health context,¹²⁴ practitioners were wary that the failure to regulate those standards would perpetuate inequity and undermine the promise of parity.¹²⁵ The Senate-passed bill, which contained weaker consumer protections than the House-passed bill, would have preserved many of these practices. It explicitly allowed plans to negotiate separate reimbursement or provider rates and service delivery systems for different benefits; to manage the provision of mental health and substance use disorder services through “utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health” and contracting with network providers; and to apply parity standards “in a manner that takes into consideration similar treatment settings or similar treatment.”¹²⁶ Congress dropped these provisions in the final parity legislation.

¹²² Medical management standards are contemplated by the statutory language requiring disclosure of “the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits.” 26 U.S.C.A. § 9812(a)(4) (Westlaw 2012); 29 U.S.C.A. § 1185a(a)(4) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(a)(4) (Westlaw 2012).

¹²³ INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COSTS 28-29 (2012) (describing medical plan benefit design to include, among other items, utilization management, identification of provider networks, and approaches designed to influence the use of services, such as prior authorization).

¹²⁴ The economic impact analysis of the Parity Act Interim Final Rule emphasized that “medical management and managed care techniques will help control any major cost impact resulting from [the Parity Act] and these regulations.” Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5425 (Feb. 2, 2010). The regulating agencies reviewed a study that examined parity under FEHBP and found that managed behavioral health strategies had, in part, controlled consumer response to reduced cost-sharing (the moral hazard problem) and would likely operate in the same way under the Parity Act. *Id.* at 5424-25.

¹²⁵ See KENNEDY & RAMSTAD, *supra* note 92, at 16 (citing testimony of Dr. Steven Sharfstein, Exec. Dir., Sheppard Pratt Health Sys., Balt., Md.); see also Letter from Scott Rauch, President of McLean Hosp., to Ctr. for Medicare & Medicaid Servs. (Apr. 30, 2010), available at www.dol.gov/ebsa/pdf/1210-AB30-5327.pdf (stating that the oversight of specialized managed care carve-out firms is “far more rigorous for behavioral health than . . . for medical/surgical services. . . . Clinicians are constantly questioned and micro-managed by Carve-Out reviewers as to the medical necessity of a given behavioral health service”); Katherine C. Nordal, Exec. Dir. for Prof’l Practice, Am. Psychological Ass’n Practice Org., to Dep’ts of Treasury, Labor & Health & Human Servs., 4-5 (May 3, 2010), available at www.dol.gov/ebsa/pdf/1210-AB30-5089.pdf (citing intensive medical management, including intrusive telephone interviews used to discourage psychologists and their patients from seeking needed care).

¹²⁶ S. 558, 110th Cong. § 2(b) (2007). This “clarifications” section separated these medical management features from the financial restrictions and treatment limitations that were subject to the Senate-passed bill’s non-discrimination standard. *Id.* Under the Senate-passed bill, as long as a plan did not provide separate or more restrictive financial requirements or treatment limitations to mental health and substance use disorder benefits, it would have been able to retain separate and distinctive plan designs for those benefits. *Id.* § 2(a).

These compromises undoubtedly paved the path to passage of the Parity Act. At the same time, they created fodder for a contentious regulatory process¹²⁷ and uncertainty as to how far health plans must go to equalize coverage of behavioral health services. As discussed in Parts II and III, the Parity Act's regulatory standards address both issues: the scope of mental health and addiction treatment services and medical management standards. The law's ability to end pervasive insurance discrimination will turn largely on the interpretation and enforcement of the provisions regarding these two issues.

II. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT: NON-DISCRIMINATION STANDARDS

The Parity Act and its regulations set out rules that address treatment limitations, financial requirements, and medical management features that have both limited and increased the cost of addiction and mental health care for consumers.¹²⁸ The law's measure of equality is whether the plan's standards for these features are "comparable" for behavioral health and medical care. The law requires health plans to (1) identify treatment limitations and financial requirements that are imposed on the addiction or mental health benefit, (2) compare those specific standards to the coverage that applies to medical services, and (3) modify any standard that is "separate from or more restrictive than" those imposed on medical services. The Parity Act's Interim Final Regulations (IFR) set out a separate comparability standard for medical management (and other non-quantifiable treatment limitations) requirements. It bars any limitation on mental health or addiction services that is not comparable to or is applied more stringently than medical management standards for medical services. A detailed description of these standards is provided to assist employers and carriers in developing parity-compliant plans and to equip plan participants and providers to assert their rights to appropriate treatment and payment.

¹²⁷ See Barry et al., *supra* note 4, at 423 (noting tendency of interest groups to refight policy battles at the rule-making stage, which occurred even though groups were united to win passage of the law).

¹²⁸ See Barry et al., *supra* note 47, at 630, 632 (describing benefit limitations as "demand-side" rationing, as compared to "supply-side" rationing through managed care); see also Frank et al., *supra* note 10, at 116-18. (outlining the ways in which medical management can use administrative tools to discourage enrollment by making partial hospitalization difficult to access or contracting with residential providers that are located in inaccessible or undesirable neighborhoods; noting that managed care has many more ways to "affect the effective coverage of a plan" than the earlier design features of cost-sharing and benefit limits).

As a civil rights statute, the Parity Act addresses disparate treatment,¹²⁹ although no proof of intent to discriminate is required to invalidate insurance practices that do not conform to the IFR's "proof" of comparability. Apart from the permission to exclude all coverage for mental health and substance use disorders,¹³⁰ the Parity Act's regulatory standards are most akin to Title VII sex discrimination standards. Those standards require employer-based health insurance to provide comparably comprehensive services for men and women,¹³¹ without consideration of actuarial data,¹³² and bar both disparate treatment and disparate-impact discrimination.¹³³ The Title VII standard, which requires health plans to provide equally comprehensive services for men and women even though certain reproductive health services are unique

¹²⁹ It is helpful to analogize the parity standard to other civil rights standards for purposes of determining whether a specific practice constitutes a violation. A formulation that focuses on "separate," "more restrictive," and "non-comparable" standards fits comfortably within the actions that constitute discrimination under Title VII. *See, e.g.*, 29 C.F.R. § 1604.10(b) (Westlaw 2013) (requiring payments under any health insurance plans to be applied to disability due to pregnancy, childbirth, or related medical conditions on the same terms and conditions as they are applied to other disabilities); 29 C.F.R. § 1604.9(d) (Westlaw 2013) (making it unlawful for an employer to make fringe benefits, including health benefits, available to spouses or families of employee of one gender if the same benefits are not provided to spouses or families of opposite gender employees).

¹³⁰ *Cf.* 29 C.F.R. § 1604.9(b), (d) (making it unlawful for an employer to exclude employees of one gender from benefits that the other gender receives, and "[a]n example of such an unlawful employment practice is a situation in which wives of male employees receive maternity benefits while female employees receive no such benefits").

¹³¹ *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 685 (1983) (holding that health insurance benefits for pregnancy-related conditions that provide more comprehensive services for female employees than for the wives of male employees violate Title VII).

¹³² 29 C.F.R. § 1604.9(e) ("It shall not be a defense under title VII to a charge of sex discrimination in benefits that the cost of such benefits is greater with respect to one sex than the other."); *City of L.A., Dep't of Water & Power v. Manhart*, 435 U.S. 702, 716-17 (1978) (holding that there was no cost justification defense under Title VII). Similarly, the Parity Act does not allow different standards based on the cost of mental health or substance use disorder services. The only cost-related variations that are allowed under the Parity Act relate to cost exemptions from coverage. A plan may be granted an exemption from coverage for a single plan year if the plan's actual cost of providing both medical and mental health/substance use disorder benefits increases by 2% in the first six months of coverage (and by 1% in each subsequent plan year). 26 U.S.C.A. § 9812(c)(2) (Westlaw 2012); 29 U.S.C.A. § 1185a(c)(2) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(c)(2) (Westlaw 2012).

¹³³ *Griggs v. Duke Power Co.*, 401 U.S. 424, 431 (1971) ("[Title VII] proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation."); *see also* EEOC, EEOC COMPLIANCE MANUAL (2000), available at www.eeoc.gov/policy/docs/benefits.html#N_93_. The Parity Act does not, however, invalidate plan management practices that have a disparate impact on the delivery of mental health/substance use disorder services. 26 C.F.R. § 54.9812-1T(c)(4)(iii) ex. 3 (Westlaw 2013); 29 C.F.R. § 2590.712(c)(4)(iii) ex. 3 (Westlaw 2013); 45 C.F.R. § 146.136(c)(4)(iii) ex. 3 (Westlaw 2013); *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, U.S. DEP'T OF LABOR (last accessed Feb. 21, 2013), www.dol.gov/ebsa/faqs/faq-aca7.html.

to one gender, suggests that a similar conceptual dilemma—the lack of a perfect “apples-to-apples” comparison between behavioral health and medical care—need not be fatal to enforcement.

A. QUANTIFIABLE TREATMENT LIMITATIONS AND FINANCIAL REQUIREMENTS

The Parity Act and regulations¹³⁴ target financial requirements and treatment limitations that prevent individuals from accessing the care they need and that ignore the chronic nature of mental health and substance use disorders. Treatment limitations “include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.”¹³⁵ Financial requirements include “deductibles, copayments, coinsurance, and out-of-pocket expenses,” with the exception of aggregate lifetime financial limits or annual financial limits, which the law addresses separately.¹³⁶

¹³⁴ The Parity Act regulations, which, as of the time of publication, constitute an Interim Final Rule (IFR), provide substantial guidance for implementation. 26 C.F.R. § 54.9812-1T (Westlaw 2013); 29 C.F.R. § 2590.712 (Westlaw 2013); 45 C.F.R. § 146.136 (Westlaw 2013). The Departments of Treasury, Labor, and Health and Human Services issued the IFR on February 2, 2010, after receiving comments pursuant to a Request for Information, issued in April 2009. Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 74 Fed. Reg. 19155 (Apr. 28, 2009). The agencies issued the rule as an IFR without notice of proposed rulemaking based on a “good cause” finding that prompt guidance was needed to ensure compliance with the Parity Act, which had already gone into effect as of October 3, 2009. 75 Fed. Reg. 5410, 5419 (Feb. 2, 2010). The IFR standards were applicable to health plans as of July 1, 2010, *id.* at 5410, and the agencies sought comments on a number of issues that would be addressed in the final rule. Although sub-regulatory guidance has been issued on several points, a final rule has not been promulgated. *See* *Coal. for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10, 14-15 (D.D.C. 2010) (setting out the regulatory process). A coalition of managed behavioral health organizations challenged the promulgation of the IFR, asserting that the Departments did not have authority under the Administrative Procedure Act to issue the rule as an IFR, and sought an injunction enjoining implementation of and vacating the IFR and requiring reissuance of the Rule under notice-and-comment rulemaking. *Id.* at 15-16. The district court dismissed the action, holding that the Departments properly invoked the “good cause” exception to notice-and-comment rulemaking based on congressional authorization to issue interim final rules, the need for prompt guidance, the interim nature of the IFR, and the lack of evidence of dilatory action on the part of the Departments. *Id.* at 24. Although the Coalition of Parity’s action was based on an alleged APA procedural violation, its chief goal was to challenge the substantive reach of the regulations. *See id.* at 15-16; *infra* note 166 and accompanying text.

¹³⁵ 26 U.S.C.A. § 9812(a)(3)(B)(iii) (Westlaw 2012); 29 U.S.C.A. § 1185a(a)(3)(B)(iii) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(a)(3)(B)(iii) (Westlaw 2012). The IFR also includes “days in a waiting period” as a “treatment limitation.” 26 C.F.R. § 54.9812-1T(a) (Westlaw 2013); 29 C.F.R. § 2590.712(a) (Westlaw 2013); 45 C.F.R. § 146.136(a) (Westlaw 2013).

¹³⁶ *See infra* note 147 and accompanying text. Examples of lifetime or annual financial limits would be a \$100,000 cap on insurance reimbursement for addiction care over the individual’s lifetime, or a \$50,000 cap on insurance reimbursement for the plan year.

The non-discrimination standard for these “quantitative”¹³⁷ treatment or financial features is operationalized as a mathematical formula. An insurance plan that provides a benefit for mental health or addiction disorders is prohibited from imposing a *separate* financial requirement or treatment limitation that is applicable only to the mental health or addiction benefit. In addition, the plan is prohibited from imposing a *more restrictive* financial requirement or treatment limitation on mental health or addiction disorders than the predominant level imposed on substantially all medical benefits.¹³⁸ The law defines “predominant level” as the “most common or frequent of such type of [treatment] limit or [financial] requirement.”¹³⁹ The regulations further define “substantially all” to mean at least “two-thirds” of all medical/surgical benefits in a classification, and the “predominant level” to mean the level that applies to more than half of medical benefits in that classification that are subject to the specific treatment limitation or financial requirement.¹⁴⁰ Recognizing that many plans “carve out” their mental health/substance use disorder benefits from the medical benefits, the regulations explicitly construe the mental health/substance use disorder and general medical benefits as a combined benefit in a single plan.¹⁴¹

The parity regulations provide the framework for operationalizing the “more restrictive” comparison standard. The IFR establishes six general classifications and requires all financial requirements and treatment limitations for addiction or mental health benefits to be

¹³⁷ “Quantitative” standards are those in which a limitation is stated with a numerical value (e.g., thirty days of treatment or a \$30 copayment). See 26 C.F.R. § 54.9812-1T(a) (Westlaw 2013); 29 C.F.R. § 2590.712(a) (Westlaw 2013); 45 C.F.R. § 146.136(a) (Westlaw 2013).

¹³⁸ 26 U.S.C.A. § 9812(a)(3)(A) (Westlaw 2012); 29 U.S.C.A. § 1185a(a)(3)(A) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(a)(3)(A) (Westlaw 2012).

¹³⁹ 26 U.S.C.A. § 9812(a)(3)(B)(ii); 29 U.S.C.A. § 1185a(a)(3)(B)(ii); 42 U.S.C.A. § 300gg-26(a)(3)(B)(ii).

¹⁴⁰ 26 C.F.R. § 54.9812-1T(c)(3) (Westlaw 2013); 29 C.F.R. § 2590.712(c)(3) (Westlaw 2013); 45 C.F.R. § 146.136(c)(3) (Westlaw 2013). The calculation of the “predominant” and “substantially all” level is based on the plan’s projected payments for medical/surgical benefits in the classification for the plan year. 26 C.F.R. § 54.9812-1T(c)(3)(i)(C); 29 C.F.R. § 2590.712(c)(3)(i)(C); 45 C.F.R. § 146.136(c)(3)(i)(C). The IFR permits a health plan to use “any reasonable method” to determine the dollar amount expected to be paid under a plan for purposes of calculating the medical/surgical benefits that are subject to a particular treatment limitation or financial requirement as well as the level of such requirement. 26 C.F.R. § 54.9812-1T(c)(3)(i)(E); 29 C.F.R. § 2590.712(c)(3)(i)(E); 45 C.F.R. § 146.136(c)(3)(i)(E).

¹⁴¹ 26 C.F.R. § 54.9812-1T(e)(1); 29 C.F.R. § 2590.712(e)(1); 45 C.F.R. § 146.136(e)(1); Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5418 (Feb. 2, 2010) (noting the need for this construction to avoid a potential evasion of the law by offering mental health or substance use disorder benefits in a separately administered carve-out arrangement that has no medical benefits, even though the latter are otherwise provided by the group plan).

compared with the benefits for medical services in each classification. The classifications are inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, prescription drugs, and emergency care.¹⁴² The analysis proceeds by identifying three items: (1) any treatment limitation or financial requirement that exists for the addiction/mental health benefit; (2) the service to which the feature applies (outpatient, inpatient, prescription drug, or emergency care); and (3) whether the plan is an in-network or out-of-network plan. That feature is then compared with the medical benefit under the same service and provider network system.

Parity compliance focuses on two questions. First, does the “type” of treatment limitation or financial requirement imposed on mental health/substance use disorder benefits apply to two thirds of the medical benefits? If that “type” of financial requirement or treatment limitation does not apply to “substantially all” medical benefits, it violates the Parity Act’s prohibition against “separate” standards for mental health/substance use disorder benefits.

Second, what “level” of that limitation or requirement applies to more than half of the medical benefits in that same classification? To determine the predominant level, the plan looks to the projected plan payments of medical/surgical benefits. If no single level applies to more than one half of the medical benefits (at least 51%), the plan may combine the different levels until the combination amounts to more than half.¹⁴³ The predominant level is the least restrictive of the levels within the combination, and only that level may be imposed on mental health/substance use disorder benefits in that classification.¹⁴⁴

An example will help clarify the analysis. Consider a large retail employer that offers its employees a health plan that provides coverage for hospital care, primary physician and specialty care, preventive services, laboratory and x-ray procedures, surgical procedures,

¹⁴² 26 C.F.R. § 54.9812-1T(c)(2)(ii)(A); 29 C.F.R. § 2590.712(c)(2)(ii)(A); 45 C.F.R. § 146.136(c)(2)(ii)(A). Out-of-network standards are included because health plans that provide coverage for medical benefits through out-of-network providers are required by law to also provide mental health/ substance use disorder benefits through out-of-network providers. 26 U.S.C.A. § 9812(a)(5) (Westlaw 2012); 29 U.S.C.A. § 1185a(a)(5) (Westlaw 2012); 42 U.S.C.A. §300gg-26(a)(5) (Westlaw 2012).

¹⁴³ 26 C.F.R. § 54.9812-1T(c)(3)(i)(B)(2) (Westlaw 2012); 29 C.F.R. § 2590.712(c)(3)(i)(B)(2) (Westlaw 2012); 45 C.F.R. § 146.136(c)(3)(i)(B)(2) (Westlaw 2012). In combining levels, the regulations permit a plan to start with the most restrictive level and add less restrictive levels until it reaches over half of projected plan payments.

26 C.F.R. § 54.9812-1T(c)(3)(i)(B)(2); 29 C.F.R. § 2590.712(c)(3)(i)(B)(2); 45 C.F.R. § 146.136(c)(3)(i)(B)(2).

¹⁴⁴ 26 C.F.R. § 54.9812-1T(c)(3)(i)(B)(2); 29 C.F.R. § 2590.712(c)(3)(i)(B)(2); 45 C.F.R. § 146.136(c)(3)(i)(B)(2).

physical/occupational/speech therapy, chiropractic care, acupuncture, home health services, reproductive health, emergency services, prescription drugs, and mental health and substance use disorder care. The plan requires a \$20 copayment for each outpatient counseling visit for mental health or addiction treatment provided by an in-network provider. It requires several different copayments for medical services provided on an outpatient, in-network basis: preventive services and reproductive health office visits have no copayment; primary care visits for treatment of an illness or injury have a \$10 copayment; laboratory work has a \$15 copayment; physical/occupational/speech therapy, chiropractic care, and acupuncture have a \$20 copayment; and specialty care visits have a \$25 copayment. The plan estimates \$1 million in plan payments for medical benefits in the outpatient, in-network classification. Chart 1 shows the various copayment levels and hypothetical projected portion of plan payments¹⁴⁵ for each category of outpatient, in-network medical benefits.

CHART 1

Service	Preventive or Reproductive Health	Primary Care Visit for Physical Illness or Injury	Lab Work	Physical, Occupational, or Speech Therapy; Chiropractics; Acupuncture	Specialty Care
Co-Payment	\$0	\$10	\$15	\$20	\$25
% of Projected Plan Payments	20%	20%	20%	20%	20%

Under the parity analysis, the \$20 copayment for addiction/mental health outpatient care is compared to the copayment scheme for outpatient, in-network medical benefits. If a copayment is not required for substantially all of those medical benefits, the addiction/mental health

¹⁴⁵ This proportion of projected plan payments is selected for ease of example. The IFR offers a more nuanced example of projected plan costs. 26 C.F.R. § 54.9812 (c)(3)(iv); 29 C.F.R. § 2590.712(c)(3)(iv); 45 C.F.R. § 1146.136(c)(3)(iv).

copayment is a “separate” standard and, thus, invalid. Since 80% of all outpatient, in-network medical benefits require a copayment, one may be imposed on addiction/mental health benefits.

The analysis then proceeds to determine if the “level” of the copayment for mental health/substance use disorders (\$20 in this example) matches the predominant level of the plan’s medical benefits. No single copayment level equates to more than 50% of the projected copayments for outpatient, in-network medical benefits (i.e., each copayment level constitutes 25% of the total projected copayments).¹⁴⁶ Consequently, the plan must combine levels, starting with the most restrictive level (\$25), to reach a composite level that is applied to more than one-half of projected plan payments for outpatient, in-network medical benefits. In this example, only 50% of outpatient medical benefits have a copayment of \$20 or more. Adding the next copayment level (\$15) reaches 75% of outpatient medical benefits and, therefore, meets the required percentage of projected plan payments. Of the combined copayment levels, the least restrictive amount—and therefore the predominant level—is the \$15 copayment. Accordingly, a \$20 copayment for mental health/substance use disorder services violates the Parity Act, because it is more restrictive than the predominant level.

This same analysis applies to all other quantifiable treatment limitations and financial requirements (with slight variations for annual and lifetime limitations)¹⁴⁷ to determine whether, for example, a thirty-

¹⁴⁶ Of the \$1 million in projected plan costs, services that have a copayment amount to \$800,000 in plan costs. Since each copayment level is estimated to have 20% of the projected plan payment, each constitutes 25% of those projected costs.

¹⁴⁷ The law defines “aggregate lifetime limit” as “a dollar limitation on the total amount that may be paid with respect to such benefits under the plan with respect to an individual” 26 U.S.C.A. § 9812(e)(1) (Westlaw 2012); *see also* 29 U.S.C.A. § 1185a(e)(1) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(e)(1) (Westlaw 2012). The law defines “annual limit” as “a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan with respect to an individual” 26 U.S.C.A. § 9812(e)(2); *see also* 29 U.S.C.A. § 1185a(e)(2); 42 U.S.C.A. § 300gg-26(e)(2). The law retains separate standards for these features because the Mental Health Parity Law of 1996 barred discrimination in annual and lifetime limits for mental health care, and Congress retained that framework under the expanded law. An annual or lifetime dollar limit that applies to mental health or addiction benefits is compared with the dollar amount of any such limit imposed on medical benefits. To the extent no such limitations exist for medical benefits, an annual or lifetime cap may not be imposed on mental health or addiction benefits. 26 U.S.C.A. § 9812(a)(1), (2); 29 U.S.C.A. § 1185a(a)(1), (2); 42 U.S.C.A. § 300gg-26(a)(1), (2). If an annual or lifetime limit applies to substantially all (two thirds of) medical benefits, then a plan is required either to apply the limit imposed on medical benefits to both those benefits and the mental health or addiction benefit or to apply a separate annual or lifetime cap to the mental health or addiction benefit that is no less than the dollar level imposed on medical benefits. 26 U.S.C.A. § 9812(a)(1), (2); 29 U.S.C.A. § 1185a(a)(1), (2); 42 U.S.C.A. § 300gg-26(a)(1), (2). The law sets out an additional standard if different annual or lifetime limits are imposed on different categories of medical benefits. 26 U.S.C.A. § 9812(a)(1), (2); 29 U.S.C.A. § 1185a(a)(1), (2); 42 U.S.C.A. § 300gg-26(a)(1), (2).

session limit on outpatient mental health counseling or a two-day limit on adolescent residential treatment is permissible under parity. Returning to the example of the retail employer's health plan, it contains no annual limit on the number of outpatient sessions for physician and specialty care, preventive services, and reproductive health care; a thirty-session limit for physical/occupational/speech therapy; a fifteen-session limit for chiropractic care and acupuncture; and a fifteen-session limit for outpatient mental health/substance use disorder care. To determine if a plan may impose a fifteen-session limit on behavioral health services, the plan would first determine whether two thirds of the outpatient medical/surgical benefits have a day limit. If they do not, a treatment limitation may not be imposed on outpatient mental health/substance use disorder care. If this threshold is satisfied, then a determination must be made whether a fifteen- or thirty-session limit is the predominant level, and that same level must be applied to mental health/substance use disorder outpatient services.

1. *Cross-Classification Parity*

A second significant regulatory standard revolves around the six classifications and addresses, in part, the scope of addiction or mental health services that must be provided under the Parity Act. The IFR requires that, to the extent a plan provides a benefit for an addiction disorder or a mental health condition in one of the six classifications, it must provide a benefit for the condition in each of the classifications in which a benefit is provided for medical care.¹⁴⁸ Thus, if prescription medication for an addiction or a mental health disorder is included under the health plan, then inpatient and outpatient care (both in and out-of-network) and emergency care for that disorder must also be provided if the plan offers medical services benefits in each of those classifications. As explained in the IFR, the exclusion of benefits in a classification for a mental health or addiction condition that is otherwise covered for a medical condition constitutes "a limit, at a minimum, on the type of setting or context in which treatment is offered."¹⁴⁹

Insurance plans question how this requirement can be reconciled with the Parity Act's separate regulatory standard that allows a plan to offer benefits for one or more mental health condition or substance use

¹⁴⁸ 26 C.F.R. § 54.9812-1T(c)(2)(ii)(A) (Westlaw 2013); 29 C.F.R. § 2590.712(c)(2)(ii)(A) (Westlaw 2013); 45 C.F.R. § 146.136(c)(2)(ii)(A) (Westlaw 2013).

¹⁴⁹ Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5413 (Feb. 2, 2010).

disorder without providing benefits for any other such condition.¹⁵⁰ The IFR notes that the rule requiring parity across classifications “does not require an expansion of the range of mental health conditions or substance use disorders covered under the plan”; it just requires comparable care for those covered conditions.¹⁵¹ Although inherently logical, this standard, according to some insurance industry observers, exceeds the statutory standard, which permits the denial of all coverage for addiction or mental health care and gives the plan discretion to determine the scope of services provided.¹⁵² Industry representatives have objected to being required to cover a broad range of services by virtue of plan coverage of prescription mental health medications, which, as explained above, is typically a benefit that is included in the same formulary as medications for purely physical conditions.¹⁵³

2. *Cumulative Treatment Limitations and Financial Requirements*

The IFR also regulates (1) financial requirements that impose a cumulative dollar amount as either a threshold needed to trigger insurance reimbursement—most commonly a deductible—or a cap on an insured’s payment obligation (total out-of-pocket expenses), and (2) treatment limitations that similarly cumulate to restrict the quantity of care covered, such as an annual or lifetime day or visit limit.¹⁵⁴ The IFR bars separate cumulative standards for medical and mental health/substance use disorder benefits in any classification.¹⁵⁵ Instead, it requires the application of a single cumulative level for both sets of benefits such that any care the individual receives for either medical or mental health/substance abuse disorder care is counted against a single financial amount and/or treatment limitation.¹⁵⁶ The IFR notes that a

¹⁵⁰ 26 C.F.R. § 54.9812-1T(e)(3)(i); 29 C.F.R. § 2590.712(e)(3)(i); 45 C.F.R. § 146.136(e)(3)(i).

¹⁵¹ Interim Final Rules, 75 Fed. Reg. at 5413.

¹⁵² Letter from Anthony M. Kotin, *supra* note 62, at 8-9; Letter from Justine Handelman, *supra* note 56, at 11-12.

¹⁵³ Letter from Anthony M. Kotin, *supra* note 62, at 9-10; Letter from Justine Handelman, *supra* note 56, at 12; Letter from Sheryl Bonner, Boon-Chapman Benefit Administrators, 1-2 (May 3, 2010), available at www.dol.gov/ebsa/pdf/1210-AB30-5303.pdf.

¹⁵⁴ 26 C.F.R. § 54.9812-1T(a) (Westlaw 2013); 29 C.F.R. § 2590.712(a) (Westlaw 2013); 45 C.F.R. § 146.136(a) (Westlaw 2013).

¹⁵⁵ 26 C.F.R. § 54.9812-1T(c)(3)(v); 29 C.F.R. 2590.712(c)(3)(v); 45 C.F.R. § 146.136(c)(3)(v).

¹⁵⁶ 26 C.F.R. § 54.9812-1T(c)(3)(v); 29 C.F.R. 2590.712(c)(3)(v); 45 C.F.R. § 146.136(c)(3)(v). The regulatory agencies adopted this formulation notwithstanding insurance carrier suggestions that the dollar amount of a single combined deductible could be set higher than two separate but equal deductibles and thereby increase out-of-pocket costs required to access any health service. See, e.g., Letter from Anthony M. Kotin, *supra* note 62, at 12. The “parity” response to this

single cumulative requirement is more consistent with the Parity Act's underlying policy that "mental health and substance use disorder benefits are integral components of comprehensive health care and generally should not be distinguished from medical/surgical benefits."¹⁵⁷

3. Prescription Drug Standards

As described in Part I, prescription drugs are widely used for mental health care and are generally included in the same formulary as medications for medical conditions, rather than managed separately in a carve-out plan.¹⁵⁸ These medications, like others, are often placed in tiers based on factors such as cost and efficacy, and without regard to whether they are prescribed for a mental health or substance use disorder. The IFR modeled a special parity rule on existing practice to guide the structuring of the formulary so that, within multiple tiers, the financial requirements (generally the portion paid by the plan) for all medications will be the same.¹⁵⁹ Under the IFR, a formulary will comply with parity to the extent it applies different financial requirements to different tiers of drugs based on reasonable factors—cost, efficacy, generic versus brand name, and mail-order versus pharmacy pick-up—without regard to whether a drug is generally prescribed for a medical condition or a mental health/substance use disorder.¹⁶⁰

The regulations do not directly address the imposition of quantitative treatment limitations on drugs used to treat mental health or substance use disorders. Any such limitation, e.g., refill restrictions or quantity dispensed, presumably would be evaluated within each tier to determine if it applies to substantially all drugs in the tier and, if so, exceeds the predominant limitation level. The IFR standard does, however, explicitly require a plan's formulary to comply with provisions governing non-quantitative treatment limitations,¹⁶¹ which, as described

benefit design is that two separate deductibles would require an individual who needs both kinds of care to pay a deductible that is higher than that paid by an individual who needs only medical/surgical care. Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5415 (Feb. 2, 2010). In addition, two identical but separate deductibles impose a disproportionate cost on persons seeking mental health/substance use disorder care based on the proportional cost of that singular benefit, typically 2% to 5% of the total plan costs, compared to all other services constituting the medical/surgical benefit. *Id.*

¹⁵⁷ Interim Final Rules, 75 Fed. Reg. at 5415.

¹⁵⁸ See *supra* notes 82 and accompanying text.

¹⁵⁹ Interim Final Rules, 75 Fed. Reg. at 5415.

¹⁶⁰ 26 C.F.R. § 54.9812(c)(3)(iii) (Westlaw 2013); 29 C.F.R. § 2590.712(c)(3)(iii) (Westlaw 2013); 45 C.F.R. § 146.136(c)(3)(iii) (Westlaw 2013).

¹⁶¹ See 26 C.F.R. § 54.9812(c)(3)(iii); 29 C.F.R. § 2590.712(c)(3)(iii); 45 C.F.R. § 146.136(c)(3)(iii).

below, expose the health plan to further scrutiny if it imposes different authorization standards for medications that treat substance use disorders, excludes expensive or investigational medications for the treatment of mental health/substance use disorders, or classifies a medication differently than a drug used to treat medical conditions.

B. NON-QUANTIFIABLE TREATMENT LIMITATIONS

One of the most contentious IFR provisions is the designation of plan management standards as a form of “treatment limitations.”¹⁶² The regulations apply parity requirements to medical management standards, which as noted above are not explicitly regulated by the statute, except for notification requirements.¹⁶³ The IFR recognizes, like many mental health and substance use disorder health providers and consumers, that the “scope and duration” of care are restricted by a plan’s “non-quantitative” treatment limitations (NQTLs) as much as by treatment limitations expressed numerically (QTLs) and, therefore, regulates NQTLs as a form of “treatment limitations.”¹⁶⁴ Among the insurance practices identified as an NQTL in the regulations are medical management standards, including medical necessity or appropriateness standards; experimental or investigative treatment standards and preauthorization requirements; prescription drug formulary standards; standards for admission to provider networks and reimbursement rates; a plan’s method for determining usual, customary, and reasonable charges; “fail first” policies or “step therapy” protocols; and exclusions based on the failure to complete a course of treatment.¹⁶⁵ While most observers

¹⁶² See, e.g., Letter from Justine Handelman, *supra* note 56, at 7 (“One of the more unexpected requirements of the Regulation is the requirement for parity for non-quantitative treatment limits. Early legislative versions of the Act included parity rules for medical management, but those rules were not included as part of the final Act. Indeed, the Act only contemplates easily quantifiable treatment limits.”). But see Carter & Landau, *supra* note 1, at 43 (stating, in a pre-regulatory analysis of the Parity Act, that “[n]othing in the [Act] prohibits group health plans from imposing preexisting condition, pre-certification and medical necessity requirements on mental health benefits, provided those requirements are no more stringent than those required for medical benefits”). Indeed, a coalition of managed behavioral health organizations sued the Department of Health and Human Services to enjoin the implementation of the Interim Final Rule, asserting that the Secretary exceeded her authority under the statute by promulgating medical management standards. *Coal. for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d. 10, 11-12 (D.D.C. 2010).

¹⁶³ See *supra* text accompanying note 126. The Departments noted in the IFR that “[t]reatment limitation is not comprehensively defined under the statute. . . . [I]t is not limited to such types of limits [as limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment].” Interim Final Rules, 75 Fed. Reg. at 5413.

¹⁶⁴ *Id.* at 5416.

¹⁶⁵ 26 C.F.R. § 54.9812-1T(c)(4)(ii) (Westlaw 2013); 29 C.F.R. § 2590.712(c)(4)(ii) (Westlaw 2013); 45 C.F.R. § 146.136(c)(4)(ii) (Westlaw 2013) (identified as an illustrative list). The Institute

expected that plans would be allowed to impose medical management standards on addiction and mental health benefits,¹⁶⁶ the regulations authorize a heightened degree of scrutiny to ensure that those standards do not undermine the delivery of care that is on par with medical care.¹⁶⁷

The test for comparing NQTLs for addiction/mental health care to medical benefits looks to whether the specific standard is “comparable to” or “applied more stringently than” the standard for medical services benefits within the requisite classification. Unlike the arithmetical formula for evaluating quantitative treatment limitations, the IFR does not explicitly require that an NQTL be applied to “substantially all” (or any specific portion of) the medical services before it may be applied to mental health or addiction services.¹⁶⁸ Instead, the IFR establishes an undefined comparability standard that applies to both the facial design and application of the NQTL. It provides that the

of Medicine has identified many of these features as components of benefit design for ACA-prescribed “essential health benefits,” lending support to the IFR’s coverage of these components in mental health/substance use disorder care. INST. OF MED., *supra* note 123, at 30-31 (outlining benefit design).

¹⁶⁶ For example, the plaintiff in *Coalition for Parity, Inc. v. Sebelius* alleged that the statutory language of the Parity Act defined treatment limitations to be solely “quantitative” in nature. Complaint at ¶ 39, *Coal. for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10 (D.D.C. 2010) (Civil No. 10-527). The IFR standards for non-quantitative treatment limitations are confusing and ambiguous and fail to recognize that “medical and behavioral health benefits cannot be compared on an ‘apples to apples’ basis,” *id.* ¶ 40, and the concept of non-quantitative limitations is without “bounds,” extending to such standards as provider network composition and reimbursement rates. *Id.* ¶ 47. Responding to this alleged surprise, the court noted that behavioral health providers did, indeed, have an opportunity to address these points with the federal regulatory agencies as they developed the IFR. *Sebelius*, 709 F. Supp. 2d at 14-15. In addition, the legislative history of the parity bill reveals Congress paid significant attention to this issue, even if it did not use the IFR terms of quantitative and non-quantitative treatment limitations. See discussion *supra* accompanying notes 122-126.

¹⁶⁷ The broad reach of the regulations is supported by actuarial data presented by the Parity Implementation Coalition in response to the regulatory agencies’ April 2009 Request for Information. Letter from the Parity Implementation Coalition to Alan D. Lebowitz, Deputy Assistant Secretary for Program Operations, Employee Benefits Security Administration, U.S. Dep’t of Labor 4-5, 8-9 (May 28, 2009). For example, anecdotal information indicated that disproportionately low fee schedules are common for providers of mental health and substance use disorders and accounted for the lack of access to care for children, adolescents, and seniors. *Id.* at 17. In addition, consumers of mental health/substance use disorder services were nearly twice as likely to receive care through out-of-network providers, thereby driving up the cost of their care through out-of-pocket expenditures. *Id.*

¹⁶⁸ The IFR preamble notes that “[t]he test is applied somewhat differently to non-quantitative treatment limitations.” Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5413 (Feb. 2, 2010). The regulatory agencies have issued guidance that takes the position that the parity standard for NQTLs “does not require applying a simple arithmetic test to compare the treatment of mental health or substance use disorder benefits to the treatment of medical/surgical benefits.” *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, *supra* note 133. See *infra* note 277 for an alternative interpretation.

processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification [must be] comparable to, and . . . applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to [medical/surgical benefits] in the classification¹⁶⁹

A safe harbor provision exists to allow variations in NQTL standards if “recognized clinically appropriate standards of care . . . permit a difference.”¹⁷⁰ Although the IFR does not define “recognized clinically appropriate standards of care,” such standards should arguably be based on national criteria or peer-reviewed research that meet standards of validity and replicability rather than practice standards developed solely by the health plan.¹⁷¹

To facilitate an evaluation of the comparability of the underlying factors used to make these management determinations, the law and regulations explicitly require a health plan to disclose the criteria for medical necessity determinations regarding mental health or addiction benefits to any current or potential participant, beneficiary, or contracting provider upon request.¹⁷² Curiously, the statute and regulations do not require the disclosure of the medical necessity criteria (or other medical management standards) for medical services that the plan uses as the comparator for the mental health or addiction benefit.

To fill this gap, the regulating agencies have issued subregulatory guidance confirming that, under the Employee Retirement Income Security Act (ERISA), the medical necessity criteria for both medical and mental health/substance use disorder benefits are considered plan

¹⁶⁹ 26 C.F.R. § 54.9812-1T(c)(4)(i) (Westlaw 2013); 29 C.F.R. § 2590.712(c)(4)(i) (Westlaw 2013); 45 C.F.R. § 146.136(c)(4)(i) (Westlaw 2013).

¹⁷⁰ See 26 C.F.R. § 54.9812-1T(c)(4)(i); 29 C.F.R. 2590.712(c)(4)(i); 45 C.F.R. § 146.136(c)(4)(i). A similar medical necessity standard is imposed in the Title VII health benefit context when a plan seeks to justify a standard that has a disparate impact based on gender. See EEOC, *supra* note 133 (“If the employer applies facially neutral standards to exclude treatment for conditions or risks that disproportionately affect either men or women . . . the employer must show that the standards are based on generally accepted medical criteria.”). Scientific support for the employer’s criteria should be provided. *Id.*

¹⁷¹ Letter from Parity Implementation Coalition to Office of Health Plan Standards & Compliance Assistance and Ctrs. for Medicare & Medicaid Servs. 16-17 (Apr. 30, 2010); Sara Rosenbaum et al., *Who Should Determine When Health Care Is Medically Necessary?*, 340 NEW ENG. J. MED. 229, 232 (1999) (identifying the level of evidence an insurer should be required to produce to overturn a treating physician’s decision on medical necessity grounds).

¹⁷² 26 U.S.C.A. § 9812(a)(4) (Westlaw 2012); 29 U.S.C.A. § 1185a(a)(4) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(a)(4) (Westlaw 2012); 26 C.F.R. § 54.9812-1T(d)(1) (Westlaw 2013); 29 C.F.R. § 2590.712(d)(1) (Westlaw 2013), 45 C.F.R. § 136(d)(1) (Westlaw 2013).

documents and must be made available upon request.¹⁷³ ERISA benefit determination standards require a plan to inform, upon request, participants and beneficiaries of any internal rule, guideline, protocol, or similar criterion used in denying a health benefit as well as an explanation of the scientific or clinical judgment that supports any medical necessity determination.¹⁷⁴ In addition, a claimant who challenges a plan's adverse benefit determination is also entitled to all "documents, records and other information relevant to the claimant's claim for benefits."¹⁷⁵ Both disclosure requirements should encompass the comparable medical/surgical standards relied upon by the plan. Plans that are not subject to ERISA, such as state and local government health plans, may be subject to state law that authorizes similar access.

Looking again at the example of the retailer's health plan will help clarify the general framework for applying this standard.¹⁷⁶ Suppose all plan members are required to obtain preauthorization to obtain outpatient care for a mental health or substance use disorder from an in-network provider, regardless of the type of service (e.g., outpatient, intensive outpatient, diagnostic and psychological testing, day treatment, electroconvulsive therapy). If no outpatient in-network medical service is subject to a preauthorization requirement, it cannot be imposed on outpatient services for mental health or addiction care. The mental health/addiction standard is separate from and not "comparable" to the medical standard.¹⁷⁷ If, however, the plan applies a pre-authorization requirement for some outpatient medical services—physical, occupational, or speech therapy; home nursing visits; and outpatient surgery—as well as all outpatient behavioral health services, sub-regulatory guidance makes clear that the plan must articulate the criteria it has used to determine which services will be subject to the NQTL and

¹⁷³ *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, *supra* note 133; see also U.S. DEP'T OF LABOR, SELF-COMPLIANCE TOOL FOR PART 7 OF ERISA: HIPAA AND OTHER HEALTH CARE-RELATED PROVISIONS 29, available at www.dol.gov/ebsa/pdf/cagappa.pdf (stating that if denial is based on medical necessity criteria, criteria for both the mental health/substance use disorder benefit at issue and medical benefits in the same classification must be provided within thirty days upon request).

¹⁷⁴ 29 C.F.R. §§ 2560.503-1(g)(1)(v), 2520.104b-1 (Westlaw 2013). A plan administrator who fails or refuses to mail the information within thirty days after the request may be held personally liable and fined by a court in an amount up to \$100 per day from the date of inaction. 29 U.S.C.A. § 1132(c)(1) (Westlaw 2012).

¹⁷⁵ 29 C.F.R. § 2560.503-1(h)(2)(iii), (3). "Relevant" information includes any document that was relied upon in making the benefit determination and any document submitted, considered, or generated in the course of making the benefit determination, even if not relied upon. *Id.* § 2560.503-1(m)(8).

¹⁷⁶ For further analysis on implementation questions, see discussion *infra* Part III.B.

¹⁷⁷ See generally *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, *supra* note 133.

demonstrate that those same criteria are applied across both behavioral health and medical services.¹⁷⁸ A finding of comparability is more likely to be established if the plan's strategies, processes, and factors are based on an array of medically recognized standards and protocols, and the application of such factors results in the NQTL being imposed in a differentiated fashion to specific health benefits across both medical conditions and mental health/substance use disorders.¹⁷⁹

Sub-regulatory guidance also clarifies that a plan will not satisfy the comparability standard simply by ensuring an NQTL also applies to at least one or several medical/surgical services.¹⁸⁰ Indeed, federal regulators have stated that a plan would not likely satisfy the parity standard if, as in the example above, all behavioral health outpatient services, but only a limited number of outpatient medical services, were subject to preauthorization. According to the guidance, "it is unlikely that the processes, strategies, evidentiary standards, and other factors considered by the plan in determining that those three (and only those three) outpatient medical/surgical benefits require prior authorization would also result in *all* outpatient [behavioral health] benefits needing prior authorization."¹⁸¹ Such a pattern could indicate that the plan is singling out behavioral health care for more restrictive treatment rather than developing a set of standards that is applied consistently across all medical and behavioral conditions.¹⁸²

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* Question 4, for example, describes with approval a plan that uses a wide range of factors to design medical management techniques based on medical literature and professional standards. *Id.* The factors include cost of treatment, high cost growth, variability in cost and quality, elasticity of demand, provider discretion in determining diagnosis or type or length of treatment, clinical efficacy of proposed treatment, licensing and accreditation of providers, and claims type with a high percentage of fraud. *Id.* The use of these factors results in an NQTL (prior authorization in this case) being imposed on some, but not all, mental health and addiction services and a wide range of medical conditions. The regulators indicate this approach seems to implement NQTLs in a comparable fashion and does not apply the standards more stringently in practice. *Id.*

¹⁸⁰ *See generally id.* The absence of a numerical threshold standard for the application of NQTLs means that the existence of the same type of NQTL requirement for *any* medical benefit arguably amounts to a "comparable" NQTL, thereby satisfying the "comparability as written" standard. *See* discussion *infra* Part III.B for further guidance on comparability determination.

¹⁸¹ *Id.* (emphasis added).

¹⁸² A similar analysis has been applied in a Title VII health benefits case. The court in *Erickson v. Bartell Drug Co.*, a Pregnancy Discrimination Act case, examined whether the exclusion of prescription contraceptives from the plan's formulary violated the Act. *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1268 (W.D. Wash. 2001). The court acknowledged that the plan's formulary excluded prescription drugs other than prescription contraceptives, but the defendant could not provide a "consistent theory" to explain the various inclusions and exclusions. *Id.* at 1275. The court concluded that a "generally comprehensive" policy that excluded prescription contraceptives "circumscribed the treatment options available to women, but not to men." *Id.* at 1276.

Sub-regulatory guidance additionally indicates that the “as applied” prong of the comparability standard requires evidence of disparate implementation practices, as opposed to disparate results. Take, for example, the retail employer’s plan that requires preauthorization for all inpatient medical and behavioral health services, but whose utilization review agents routinely approve seven days of care for medical services and only two days for mental health/substance use disorder care prior to requiring a treatment plan. The regulating agencies construe this disparate treatment to violate the “applied no more stringently” provision, because the standard applied to benefits for all mental health/substance use disorders is stricter than the standard applied to medical services. While a clinically appropriate standard of care could justify different prior authorization standards or practices for “individual conditions or treatments,” the lack of differentiation among behavioral health conditions suggests the application of a blanket standard that is not based on a clinical standard of care.¹⁸³ On the other hand, a uniformly applied utilization management standard would not violate the “applied no more stringently” standards even if the application resulted in a disparate impact.¹⁸⁴ Evidence of disparate treatment in implementation may be found in a plan’s utilization management protocols or through its claims data.¹⁸⁵

C. ENFORCEMENT STANDARDS

The Departments of Labor (DOL), Health and Human Services (HHS), and Treasury have shared responsibility under the Parity Act,

¹⁸³ *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, *supra* note 133.

¹⁸⁴ *Id.* (explaining that a concurrent review requirement that is imposed on all medical and mental health/substance use disorder services that have a high variation in the length of stay would not violate the “applied no more stringently” standard even if it applies to a higher percentage of behavioral health conditions than medical conditions).

¹⁸⁵ For example, the Chair of the Psychiatry Department for the Baltimore Washington Medical Center has observed that, while all health plans require preauthorization for inpatient care for both medical and behavioral health conditions, the process for obtaining approval is distinctively different. Testimony of Dr. Steven Daviss, Congressional Forum Testimony on the Implementation and Enforcement of MHPAEA, Chevy Chase, Md. (June 26, 2012) (on file with author). Emergency department staff who seek approval to admit a suicidal patient spend thirty to forty-five minutes answering a litany of questions and waiting for data to be entered into electronic record systems, while the staff seeking approval for admission of a person with a medical condition spend no more than two to three minutes providing the name of the patient, insurance number, and reason for hospitalization. *Id.* Similarly, I have investigated whether a plan’s exclusion for court-ordered treatment would violate the Parity Act. Although the exclusion, as drafted in the plan, may apply to all medical and behavioral health care, a review of claims would reveal if the exclusion is applied more stringently for substance use disorder care, which is frequently required as an alternative to incarceration.

along with the states, to enforce the statute.¹⁸⁶ DOL and Treasury generally enforce the parity requirements for private, employment-based group health plans. HHS has direct enforcement authority over non-federal governmental plans, i.e., those sponsored by state and local government employers.¹⁸⁷ State insurance departments have primary enforcement responsibility regarding issuers of health insurance in the individual or group market, although HHS may intervene to enforce rights if it finds that a state has failed to “substantially enforce” the law.¹⁸⁸

Apart from the authority to issue regulations and coordinate interpretations and rulings, the Parity Act provides virtually no framework for enforcement.¹⁸⁹ Congress did not create a private right of action in the Parity Act, and it is also unlikely that courts would find an implied right of action under *Cort v. Ash*¹⁹⁰ absent clear congressional intent.¹⁹¹ Persons who have been harmed by a plan’s violation of the Parity Act are afforded the remedies provided under ERISA, the Public Health Services Act, and the Internal Revenue Code. These laws provide

¹⁸⁶ Pub. L. No. 110-343, § 512(d), 122 Stat. 3765 (2008) (requiring all three agencies to promulgate regulations); *id.* § 512(f) (requiring a memorandum of understanding to ensure that regulations, rulings, and interpretations that apply to matters that more than one Secretary has responsibility for will be administered to have the same effect). The three federal agencies operate pursuant to a Memorandum of Understanding created after enactment of the Mental Health Parity Act of 1996. See U.S. DEP’T OF LABOR, UNDERSTANDING IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, 1 (May 9, 2012), available at www.healthreformgps.org/wp-content/uploads/faq-mhpaimplementation.pdf (citing 64 Fed. Reg. 70164 (Dec. 15, 1999)); implementing the Memorandum of Understanding for Enforcement of the Mental Health Parity Act of 1996, the Health Insurance Portability and Accountability Act of 1996, and other federal statutes).

¹⁸⁷ 42 U.S.C.A. § 300gg-22(b)(1)(B) (Westlaw 2012).

¹⁸⁸ *Id.* § 300gg-22(a)(1), (2). HHS may impose a civil penalty for health insurance issuers and non-federal governmental employers that fail to comply with the Parity Act. *Id.* § 300gg-22(b)(2)(A), (B), (C).

¹⁸⁹ The amendment to ERISA authorizes the federal agencies to issue guidance on the requirements of the Parity Act and to provide assistance concerning the law’s requirements and available assistance from state consumer and insurance agencies. 29 U.S.C.A. § 1185a(g) (Westlaw 2012).

¹⁹⁰ 422 U.S. 66, 78-85 (1975) (establishing standards for finding an implied right of action).

¹⁹¹ *Alexander v. Sandoval*, 532 U.S. 275, 286-87 (2001). Courts have concluded that other legislative acts affording healthcare protections to individuals through amendments to subchapter I of ERISA and/or the Public Health Services Act do not create a private right of action in light of ERISA’s comprehensive remedial scheme and the absence of legislative intent. See, e.g., *Howard v. Coventry Health Care, of Iowa, Inc.*, 293 F.3d 442, 445 (8th Cir. 2002) (per curiam) (finding no private right of action under Women’s Health and Cancer Rights Act); *O’Donnell v. Blue Cross Blue Shield of Wyo.*, 173 F. Supp. 2d 1176, 1180 (D. Wyo. 2001) (holding that a review of the Health Insurance Portability and Accountability Act’s enforcement provisions reveals no congressional intent to create private right of action and that enforcement is vested with states or Secretary of HHS).

three enforcement tools that, as described below, are limited in scope by ERISA's remedial scheme.¹⁹²

1. *ERISA Civil Actions*

Plan participants and beneficiaries with self-insured or fully insured group health plans may bring actions under ERISA's civil enforcement provisions¹⁹³ to challenge Parity Act violations. The two actions that will likely be brought are actions challenging a denial of benefits¹⁹⁴ and actions to enforce employee benefit rights—including the Parity Act rights—under ERISA.¹⁹⁵ The first action gives an individual the right to challenge the underlying standard that was the basis for the denial of coverage or reimbursement as being non-compliant with the Parity Act. The second action gives individuals the right to challenge a wide range of non-compliant plan design features that may not be amenable to a claims-denial challenge or that can be addressed prospectively, without awaiting a service denial.

In an action for denial of benefits—the most common vehicle to enforce rights under ERISA—an individual would assert a two-pronged challenge to a denial of care based on medical necessity, utilization review standards, or covered services. The complainant would allege first that an erroneous application of the plan's medical necessity criteria or other standard resulted in the denial of care or reimbursement, and second that the application of non-comparable medical necessity criteria or other medical management standards violated the Parity Act. Consumers with “non-grandfathered” group health plans, as defined by

¹⁹² A detailed analysis of the enforcement options is beyond the scope of this Article, as is an examination of state remedies that may exist for violations of state health insurance laws that are not preempted by ERISA. See 29 U.S.C.A. § 1144(a), (b)(2)(A) (Westlaw 2012) (providing the preemption standard).

¹⁹³ *Id.* § 1132. Government employees cannot challenge Parity Act violations under ERISA, because ERISA does not regulate federal, state and local government plans. *Id.* §§ 1003(b)(1), 1002(32).

¹⁹⁴ The provision, in pertinent part, authorizes a participant or beneficiary to bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” *Id.* § 1132(a)(1)(B).

¹⁹⁵ *Id.* § 1132(a)(3) (authorizing a participant, beneficiary, or fiduciary to bring a civil action “(A) to enjoin any act or practice which violates any provision of [Subchapter I] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [subchapter I] or the terms of the plan”). Courts have found, for example, that claims for alleged violations of the non-discrimination provisions of the Insurance Portability and Accountability Act of 1996 (HIPAA), found in subchapter I of ERISA, may be brought under § 1132(a)(3). *Werdehausen v. Benicorp Ins. Co.*, 487 F.3d 660, 667-68 (8th Cir. 2007) (holding that a HIPAA claim challenging rescission of an insurance policy for failure to disclose a pre-existing neck condition may be brought under ERISA civil action § 1132(a)(3)).

the ACA, have enhanced appeal rights that ensure an independent review of a plan administrator's denial of claims or services.¹⁹⁶ ERISA limits the remedies for violations of benefit denials to equitable relief: the provision of the benefit allowed under the plan or reimbursement for cost of the care.¹⁹⁷ Compensatory or punitive damages are not available,¹⁹⁸ and the ERISA civil enforcement provision preempts all other claims and remedies not expressly incorporated by Congress, including state extra-contractual remedies.¹⁹⁹

The dispute resolution process for benefit denial claims, known as "internal appeals and external review," generally requires plan participants and beneficiaries for both self-insured and fully insured group health plans to first appeal an adverse benefit decision through the health plan's internal administrative appeal process.²⁰⁰ Adverse decisions may then be appealed to an external independent review organization (IRO),²⁰¹ a private entity that conducts a review of a plan's

¹⁹⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2719, 124 Stat. 119, 139 (2010), 42 U.S.C.A. § 300gg-19 (Westlaw 2012). A "grandfathered" health plan is one in which a person was enrolled on the date of the ACA's enactment and that is exempt from certain ACA requirements. Grandfathered plans are governed under section 1251 of the Affordable Care Act, 42 U.S.C.A. § 18011 (Westlaw 2012), and Interim Final Regulations, 75 Fed. Reg. 34538 (June 17, 2010), *amended by* 75 Fed. Reg. 70114-01 (Nov. 17, 2010). The exclusion of grandfathered health plans means that beneficiaries of a self-insured employer plan do not have access to an independent external review of the plan's adverse decision, unless provided by the plan. Any appeal would be through the filing of a civil action. *See* 29 U.S.C.A. § 1132 (Westlaw 2012); 29 C.F.R. § 2560.503-1(c)(2) (Westlaw 2013). These same internal appeal/external review standards apply to issuers of individual health policies. 45 C.F.R. § 147.136 (Westlaw 2013).

¹⁹⁷ *See* 29 U.S.C.A. § 1132(a)(1)(B) (Westlaw 2012) (stating that participant or beneficiary has a civil enforcement action to recover "benefits due to him" and enforce or clarify rights "under the terms of the plan").

¹⁹⁸ *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985).

¹⁹⁹ *Aetna Health Inc. v. Davila*, 542 U.S. 200, 214 n.4 (2004) ("[A] state cause of action that provides an alternative remedy to those provided by the ERISA civil enforcement mechanism conflicts with Congress' clear intent to make the ERISA mechanism exclusive."); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) (concluding that the ERISA enforcement scheme is the exclusive remedy for plan participants and beneficiaries "asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of [the ERISA enforcement scheme] would pose an obstacle to the purposes and objectives of Congress").

²⁰⁰ *See* 29 U.S.C.A. § 1133 (Westlaw 2012); 29 C.F.R. §§ 2560.503-1(b), (c), 2590.715-2719(b)(2)(ii)(F) (Westlaw 2013) (providing that a claimant will be deemed to have exhausted an internal claims process if the plan does not conform to regulatory requirements beyond *de minimis* violations that do not cause harm or prejudice to the claimant and that the plan can demonstrate were for good cause or beyond the plan's control). For a discussion of the rationale for the exhaustion requirement, which is not a statutory requirement under ERISA, *see, e.g., Makar v. Health Care Corp.*, 872 F.2d 80, 83 (4th Cir. 1989); *Drinkwater v. Metro. Life Ins. Co.*, 846 F.2d 821, 825-26 (1st Cir. 1988), (finding that exhaustion was required unless the administrative route was futile or the remedy was inadequate); *Amato v. Bernard*, 618 F.2d 559, 567-68 (9th Cir. 1980) (holding that exhaustion was required unless the administrative route was futile or the remedy was inadequate).

²⁰¹ Professor Nan Hunter has characterized external/independent review organizations as both private sector administrative tribunals and public law arbitration panels. Hunter, *supra* note 22, at

internal adverse benefit determinations.²⁰² Federal regulations require IROs to apply existing state external review practices that meet the federal threshold for consumer protection²⁰³ or, alternatively, new federal standards that establish basic consumer protections and that also apply to self-insured group plans not subject to state insurance law dispute resolution procedures.²⁰⁴

Both state and federal external review standards authorize claimants to challenge adverse decisions that fall under the parity law's non-quantitative treatment limitation standard.²⁰⁵ Challenges to a plan's application of a purely quantitative treatment limitation or financial requirement, such as a maximum day limitation or cost-sharing calculation under the "substantially all"/"predominant" standard, would likely require a review of contract provisions and, therefore, would not be subject to external review by an IRO.

External review determinations are binding on an insurer, which must provide benefits and make payments in compliance with the IRO determination regardless of whether the plan seeks judicial review of that

151. They have the benefit of streamlined procedures that extend some public law values into the marketplace, but they afford claimants fewer procedural protections than administrative or judicial proceedings. *Id.* at 152.

²⁰² 26 C.F.R. § 54.9815-2719T(a)(2)(vii), (c), (d) (Westlaw 2013), 29 C.F.R. § 2590.715-2719(a)(2)(vii), (c), (d) (Westlaw 2013); 45 C.F.R. 147.136(a)(2)(vii), (c), (d) (Westlaw 2013).

²⁰³ The federal threshold for state review process compliance requires consumer protections that, at a minimum, meet the standards of the NAIC Uniform Model Act. *See* 26 C.F.R. § 54.9815-2719T(c)(1) (Westlaw 2013); 29 C.F.R. § 2590.715-2719(c)(1) (Westlaw 2013); 45 C.F.R. 147.136(c)(1) (Westlaw 2013). The requirements include, among other items, standards to ensure randomized assignment of cases to an IRO, safeguards against a conflict of interest that would influence an IRO's independence and the right of claimants to submit additional information not presented to the plan administrator for the internal appeal. 26 C.F.R. § 54.9815-2719T(c)(2); 29 C.F.R. § 2590.715-2719(c)(2); 45 C.F.R. § 147.136(c)(2).

²⁰⁴ *See generally* Roy F. Harmon, *An Assessment of New Appeals and External Review Processes—ERISA Claimants Get "Some Kind of a Hearing,"* 56 S.D. L. REV. 408 (2011) (expressing concern that the new process-oriented standards will not accomplish the regulatory goals and concluding that a claims dispute process does not address the core limitations ERISA poses for claimants, e.g., deference to plan administrator determinations, preemption of state law claims and limited remedies).

²⁰⁵ State external review processes must allow appeals of any adverse determination that relates to medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit, or one that is based on the determination that the requested care is experimental or investigational treatment. 26 C.F.R. § 54.9815-2719T(c)(2)(i), (xvi) (Westlaw 2013); 29 C.F.R. § 2590.715-2719(c)(2)(i), (xvi) (Westlaw 2013); 45 C.F.R. 147.136(c)(2)(i), (xvi) (Westlaw 2013). The federal external review standards apply to adverse decisions that involve "medical judgment." 26 C.F.R. § 54.9815-2719T(d)(1)(ii)(A), (B); 29 C.F.R. § 2590.715-2719(d)(1)(ii)(A), (B); 45 C.F.R. § 147.136(d)(1)(ii)(A), (B). The regulatory agencies have stated that "medical judgment" includes "whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act." Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37,208, 37,216 (June 24, 2011).

decision.²⁰⁶ A plan participant or beneficiary may file a civil action seeking judicial review of a plan administrator's adverse benefit determination upheld on review by the IRO.²⁰⁷ The claimant must raise any parity claims and offer supporting evidence in the plan grievance and during the IRO review process, as the administrative record is generally the exclusive source of evidence for judicial review in a benefit denial action under ERISA.²⁰⁸

The second ERISA action, under the "enforcement of rights" provision, gives an individual a basis to challenge a plan for "any act or practice" that violates ERISA provisions, including the Parity Act, and obtain appropriate equitable relief. The broad reading afforded this provision²⁰⁹ should allow a plan participant/beneficiary to challenge a wide range of violations, including more restrictive financial requirements and quantitative treatment limitations as well as non-quantitative treatment limitations. For example, an action under this provision could challenge a plan's failure to apply comparable standards for the admission of behavioral health providers to an in-network provider panel or the plan's behavioral health provider reimbursement rates. These NQTL standards affect a participant's cost of care via higher out-of-pocket expenses for out-of-network providers, but a

²⁰⁶ 26 C.F.R. § 54.9815-2719T(c)(2)(xi), (d)(2)(iv); 29 C.F.R. § 2590.715-2719(c)(2)(xi), (d)(2)(iv); 45 § C.F.R. 147.136(c)(2)(xi), (d)(2)(iv) (contemplating a plan's authority to seek judicial review of adverse IRO decision even though ERISA does not explicitly authorize plan appeals in benefit denial actions); *see* Harmon, *supra* note 204, at 419 (noting that these standards "appear to avoid a constitutional issue by including a proviso for judicial review").

²⁰⁷ *See* 29 U.S.C.A. § 1132(a)(1)(B) (Westlaw 2012); 29 C.F.R. §§ 2560.503-1(a), (h), 2590.715-2719(c)(2)(xi) (Westlaw 2013).

²⁰⁸ *See* ROBERT M. GOLDICH ET AL., ERISA: A COMPREHENSIVE GUIDE § 8-11 to 8-13 (4th ed. 2012); *see, e.g.*, *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970, 973 (9th Cir. 2006) (en banc) (holding that a district court may review the administrative record under the abuse-of-discretion standard of review only, but it may admit additional evidence on de novo review; if procedural irregularities do not constitute flagrant violations but prevent the development of a full administrative record, the court may take additional evidence to "recreate what the administrative record would have been" under an abuse-of-discretion review); *Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1203 (10th Cir. 2002) (stating that the court has flexibility to admit additional evidence in limited circumstances when administrative record is insufficient to provide de novo review); *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1025 (4th Cir. 1993) (en banc) (holding that a court has discretion to allow evidence not before administrator "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision," and identifying such good-cause circumstances); *Perry v. Simplicity Eng'g*, 900 F.2d 963, 966-67 (6th Cir. 1990) (holding that a de novo review in benefit denial suits is a review of the administrator's decision "without deference to the decision or any presumption of correctness, based on the record before the administrator").

²⁰⁹ *See* *Varity Corp. v. Howe*, 516 U.S. 489, 512 (1996) (holding that individual plan beneficiaries could bring claim for breach of fiduciary duty under § 1132(a)(3), statutory language is broad enough to encompass claims for fiduciary breach, and § 1132(a)(3) creates "'catchalls,' providing 'appropriate equitable relief' for 'any' statutory violation").

violation may be more difficult to remedy under a denial of benefits claim.²¹⁰ Similarly, a challenge to a plan's limited scope of services would be most appropriate under this cause of action as opposed to a denial of benefits claim; an action to enforce the "terms of the plan" could, by virtue of its limitations, be interpreted to not include the very services the participant would seek to obtain under the comparability standard. Finally, plan participants/beneficiaries could assert a plan-wide challenge to coverage exclusions, such as exclusions for court-ordered treatment, that often single out care for substance use disorders.²¹¹

The relief that may be awarded under the ERISA civil enforcement provisions is limited to injunctive and "other appropriate equitable" relief. Although no court has addressed the scope of the equitable relief in a health care challenge similar to one brought under the Parity Act, the Supreme Court has interpreted the standard in suits alleging a violation of fiduciary duties to mean relief that is typically available in equity, such as injunction, mandamus, and restitution, but not compensatory damages.²¹² A second legal issue that will arise under this action is whether a participant would be required to exhaust a plan's internal review procedures prior to filing an action in court.²¹³ These and other issues will require further analysis as litigation unfolds.

2. *Department of Treasury: Federal Excise Tax*

Plan beneficiaries may also seek enforcement through a federal excise tax.²¹⁴ The tax liability is generally \$100 per day for each

²¹⁰ The circuits are split on whether a plaintiff can bring claims simultaneously under § 1132(a)(1)(B) and (a)(3), with a majority holding that, under *Varity Corp.*, 516 U.S. 489, the existence of a denial of benefits claims precludes the right to bring an "enforcement of rights" action because the latter claim is available only if the beneficiary cannot avail herself or himself of another ERISA remedy. Compare *Korotynska v. Metro. Life. Ins. Co.*, 474 F.3d 101, 106-07 (4th Cir. 2006) (stating that a "great majority" of circuits preclude simultaneous claims and citing the relevant cases), with *Devlin v. Empire Blue Cross & Blue Shield*, 274 F.3d 76, 89-90 (2d Cir. 2001) (holding that claims may be brought simultaneously because plaintiff's breach of fiduciary duty claim under § 1132(a)(3) is the only claim available to address a violation if a benefit denial claim fails under § 1132(a)(1)(B)).

²¹¹ The GAO has reported that 28% of plans responding to a survey to identify plan exclusions for mental health/substance use disorders in the plan year 2010 or 2011 included an exclusion for court-ordered treatment that is a condition of probation or parole or as an alternative to incarceration. U.S. GOV'T ACCOUNTABILITY OFFICE, MENTAL HEALTH AND SUBSTANCE USE: TREATMENT EXCLUSIONS IN EMPLOYERS' HEALTH INSURANCE COVERAGE 3 (2012).

²¹² *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256-57, 260 (1993).

²¹³ Courts are split on whether exhaustion of plan review processes is required in actions brought under § 1132(a)(3) to enforce ERISA's non-discrimination provision. See *GOLDICH ET AL.*, *supra* note 208, at § 8-45.

²¹⁴ 26 U.S.C.A. § 4980D(a), (e)(1) (Westlaw 2012). The health plan would be liable for any violation involving a multi-employer plan. *Id.* § 4980D(e)(2).

individual to which the failure to comply with the Parity Act applies and continues for the duration of the non-compliance period.²¹⁵ However, the amount of the tax is subject to limitation, or is disallowed entirely, in several circumstances. First, the penalty does not apply if the IRS determines that the employer did not know of the failure to comply with the Parity Act, and, exercising reasonable diligence, would not have known that the failure existed.²¹⁶ A penalty also will not apply if the violation is due to reasonable cause and not willful negligence, and the employer corrected the violation within thirty days of the date it knew or should have known of its failure to comply with the Parity Act.²¹⁷ Correction requires that the failure must be undone to the extent possible and the individual to whom the failure applies must be placed in as good a financial position as she or he would have been in absent the failure.²¹⁸ To the extent a failure is not corrected prior to the date a notice of examination of tax liability is sent to the employer, the tax penalty can be no more than \$2,500 or, for violations that are more than de minimis, \$15,000.²¹⁹ Finally, the excise tax may be waived or reduced if the employer's failure to comply with the Parity Act was due to reasonable cause and not willful neglect, and the tax would be excessive relative to the failure involved.²²⁰ Although historically the enforcement of excise tax obligations has not been aggressive, the Internal Revenue Service is beginning to take excise tax assessments seriously.²²¹

3. *Regulatory Agency Investigations and Enforcement*

Both the DOL and HHS may initiate investigations of Parity Act violations. DOL complaints may be filed by any person or brought pursuant to the Secretary's investigative authority,²²² and the Secretary may file actions to enforce the Parity Act.²²³ HHS has more limited

²¹⁵ *Id.* § 4980D(b)(1). The non-compliance period runs from the date such failure to comply first occurs until the date of correction. *Id.* § 4980D(b)(2).

²¹⁶ *Id.* § 4980D(c)(1).

²¹⁷ *Id.* § 4980D(c)(2).

²¹⁸ *Id.* § 4980D(f)(3).

²¹⁹ *Id.* § 4980D(b)(3).

²²⁰ *Id.* § 4980D(c)(4).

²²¹ PAUL J. ROUTH, WELFARE BENEFITS GUIDE: HEALTH PLANS AND OTHER EMPLOYER SPONSORED BENEFITS § 10:14 (2011).

²²² *See* 29 U.S.C.A. § 1134(a) (Westlaw 2012). The Secretary may also require benefit plans to submit any information to the DOL that is required under the Parity Act. *See id.* § 1029(a).

²²³ *Id.* § 1132(a)(5) (giving the DOL Secretary the same authority as plan participants under § 1132(a)(3), except that the DOL may not file actions against health insurance issuers that offer health insurance coverage in connection with group plans, which enforcement remains the authority of state insurance departments).

authority to initiate investigations of alleged violations by health insurance issuers, but it may take enforcement action and impose civil penalties if the Secretary determines that a state has failed to substantially enforce a Parity Act provision.²²⁴

4. *Enforcement Limitations*

An estimated 160 parity complaints have been filed with DOL as of the end of 2011,²²⁵ but no public record of enforcement exists to date. Enforcement efforts are in their infancy and lack teeth because a final rule has not been issued. The DOL has adopted a conciliatory approach with plan administrators, seeking to work through, rather than penalize, parity violations.²²⁶ Most troubling, the agency requires only “good faith” compliance for any potentially “gray areas” in the law and regulations,²²⁷ which may perpetuate the status quo. The DOL has refused to investigate any complaint that alleges a scope-of-services violation, citing the lack of regulation on this issue.²²⁸ The agency has not provided a publicly accessible clearinghouse that delineates the nature or resolution, if any, of complaints, thus depriving employers and the public of a source of guidance for compliance.²²⁹ Parity advocates have complained that the muted enforcement response undermines the health insurance industry’s imperative and, to some degree, ability to comply with the Parity Act. This places responsibility for enforcement in the hands of claimants, who must proceed on a case-by-case basis.

Piecemeal enforcement is uniquely challenging under the Parity Act. As demonstrated by the above discussion, the regulatory standards

²²⁴ 42 U.S.C.A. § 300gg-22(a)(2), (b)(2) (Westlaw 2012).

²²⁵ Telephone Interviews with Carol McDaid, Co-Chair, Parity Implementation Coal. (Aug. 3, Dec. 1, 2011).

²²⁶ James Mayhew, Dir. Div. of Regulations & Policy, Ctrs. for Medicare & Medicaid Servs., Ctr. for Consumer Info. & Ins. Oversight, Remarks at Meeting on HHS Parity Implementation (July 12, 2012).

²²⁷ Telephone Interview with Katina Lee, Senior Emp. Benefits/Law Specialist, Dep’t of Labor Office of Health Plan Standards & Compliance Assistance (June 22, 2012).

²²⁸ Katina Lee, Senior Emp. Benefits/Law Specialist, Dep’t of Labor Office of Health Plan Standards & Compliance Assistance, Remarks at Meeting of Parity Implementation (June 11, 2012).

²²⁹ See Telephone Interviews with Carol McDaid, *supra* note 225. My experience with filing a complaint with the DOL’s District Office in Maryland to address an alleged cost-sharing violation revealed significant flaws in the investigatory process. The complaint was not reviewed for nearly three months, and the Benefits Advisor failed to investigate the complaint for another six months. See Complaint re: Johns Hopkins HealthCare LLC, filed Sept. 19, 2011) (on file with author). The Department of Labor instituted a new complaint filing process in 2011 that is designed to address the agency’s delays in reviewing and responding to complaints. See *Request for Assistance from the Department of Labor, EBSA*, U.S. DEP’T OF LABOR, www.askebsa.dol.gov/WebIntake/Home.aspx?submit=Submit+a+Complaint (last visited Feb. 13, 2013).

are complex. A consumer cannot readily determine, for example, if a plan's seemingly restrictive cost-sharing requirement or reimbursement decision that appears restrictive is, in fact, a violation of his or her rights, because all cost data and criteria required for key compliance determinations are in the exclusive control of the plan. To enforce the quantitative standards, a claimant is dependent upon the insurance carrier or plan to conduct the required plan cost analysis,²³⁰ to do so in good faith,²³¹ and to disclose that analysis to justify facially different standards for mental health/substance use disorder benefits.²³² To evaluate an NQTL challenge, a plan must be willing to conduct the analysis and provide all information related to medical benefits with comparable management standards as well as the "processes, strategies, or evidentiary standards" that have been used to develop those standards.²³³

²³⁰ For example, I direct a clinical law practice, the Drug Policy and Public Health Strategies Clinic, and have worked with students since 2010 to enforce the Parity Act through client representation and state legislative initiatives. We have investigated three large self-insured employer plans in Maryland in which the plan administrators had not conducted the required mathematical analysis to determine whether copayments for outpatient mental health/substance use disorders were parity compliant. Upon review, two of the three plans amended the financial requirement upon notification of the violation, and the third revised its subsequent year's plan following the filing of a DOL complaint. (Complaint letters on file with author).

²³¹ The regulations authorize plans to use "any reasonable method" to determine the benchmark levels of medical/surgical benefits that are subject to a financial requirement or quantitative treatment limitation (and the level of such requirements). 26 C.F.R. § 54.9812-1T(c)(3)(i)(E) (Westlaw 2013); 29 C.F.R. § 2590.712(c)(3)(i)(E) (Westlaw 2013); 45 C.F.R. § 146.136(c)(3)(i)(E) (Westlaw 2013). Carriers have taken dramatically different approaches in calculating cost data, with some using aggregate claims data across all plans they offer to arrive at the benchmark levels, as opposed to identifying a level for each particular plan. *See* Letter from Anthony M. Kotin, *supra* note 62, at 12. An insurer that uses aggregate data from all plans could arrive at a different standard than if it relied on cost data for each individual plan. For example, a self-insured employer in Maryland identified the predominant copayment level for outpatient behavioral health treatment by combining the data for two different health plans. Taken individually, the copayment was parity-compliant for one plan but not the second. When the data for the two plans were combined, however, the cost-sharing in the non-compliant plan appeared to satisfy parity because its cost data were subsumed in the second plan's data. *See* Johns Hopkins HealthCare LLC 2011 plan data (on file with author).

²³² State insurance commissioners review insurance plans for compliance with federal and state law as a prerequisite to being offered in the state. *See, e.g.*, MD. CODE ANN., INS. § 12-205(a), (b) (Westlaw 2012). The Nebraska Insurance Department has developed a set of questions that carriers are required to answer regarding application of the Parity Act for group plans. A carrier is required to identify, among other items, the predominant level for financial requirements and treatment limitations in each classification and the process for placing benefits in the six classifications and for determining the predominant levels; it also must document the mental health/substance use disorder benefit and all financial requirements and quantitative and non-quantitative treatment limitations. *See* Nebraska Dept. of Ins. Inquiry Form (on file with author).

²³³ An analysis of plan practices regarding the application of NQTLs found that MBHO "carve-out" arrangements consider the parity analysis to be a complex and costly undertaking that is made more difficult by the need to compare behavioral health standards to multiple, separate medical plans that they do not control. U.S. DEP'T OF HEALTH & HUMAN SERVS., SHORT-TERM

Even if the information were disclosed, a participant's capacity (or that of her or his health care provider) to analyze the information for compliance purposes is often limited by her or his health condition and urgency to obtain "some" care. While providers are accustomed to challenging "medical necessity" determinations through a plan's internal appeal process, they are generally not equipped to address the more complex question of whether medical standards are comparable to those for a behavioral health condition.²³⁴

Furthermore, the external review process for benefit denials, while an important right, makes systemic oversight of and corrections in a health plan unlikely,²³⁵ and it risks inconsistent decisionmaking by IROs who are not bound by a body of external review decisions.²³⁶ Historically, relatively few claimants have taken advantage of state external review procedures,²³⁷ although those who do seek review have a significant rate of success.²³⁸ For those using this process, the complexity of the parity standards will require substantial involvement of a patient's treatment provider to use the IRO process effectively and, in certain cases, assistance from medical experts to interpret evidence of

ANALYSIS TO SUPPORT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION 4-5 (2012), available at aspe.hhs.gov/daltcp/reports/2012/mhsud.pdf.

²³⁴ Students in my Drug Policy Clinic have developed parity compliance tools to assist providers in this analysis, but, based on anecdotal information, the availability of the tools has not increased the level of appeals based on parity violations.

²³⁵ Although a determination by an independent review organization is binding on a group health plan for a specific individual's claim, Professor Hunter notes that external review systems operate remarkably without precedent and may not perform the regulatory accountability function of litigation. Hunter, *supra* note 22, at 136-37. As of 2006, only three state external review laws required a "readily accessible body of prior written decisions." *Id.* The new federal external review standards require IROs to "maintain written records and make them available upon request to the State" but this does not amount to a publicly available set of opinions. See 29 C.F.R. § 2590.715-2719(c)(2)(xv) (Westlaw 2013). Health plans, as repeat players before IROs, can compile their own sets of decisions and use them for guidance, creating a significant imbalance between the parties in an individual case. Hunter, *supra*, at 137. It is also unclear whether a plan is obligated to amend its plan design if the IRO determines that a NQTL violates the Parity Act. Generally, the insurance industry has reported that it responds to external review decisions. *Id.* at 152. Although industry behavior has not been studied in the parity context, one MBHO has noted that if medical management decisions are subject to external review, it may be required to rework a plan design in the middle of a plan year based on an IRO decision. Letter from Teresa Berman, Vice Pres. & Assoc. Gen. Counsel, Magellan Health Servs., to Dep'ts of Labor, Health & Human Servs., & Treasury 6 (July 25, 2011), available at www.dol.gov/ebsa/pdf/86-2719-IFR.pdf.

²³⁶ See sources cited *supra* note 235.

²³⁷ Hunter, *supra* note 22, at 138-40 (noting that procedural requirements like exhaustion of internal grievance process and adequate notice of process contribute to low rates of use, and that Medicare's automatic appeal process results in dramatically higher utilization).

²³⁸ *Id.* at 140 (noting a 40% rate of reversal of internal decisions).

comparability for medical management standards.²³⁹ Finally, IROs will be called upon to apply the NQTL standard and determine the comparability of plan provisions, which involve different analyses than the typical medical necessity and other plan determinations. IROs require adequate education and training to carry out that analysis,²⁴⁰ and their independence must be monitored, particularly to address the perception that “repeat players” have an unfair advantage over patients.²⁴¹

The complexity, information control, and capacity factors inherent in the Parity Act structure call for additional standards that will facilitate enforcement. Part IV proposes additional enforcement tools, including annual reporting requirements so that plans demonstrate parity compliance. At the same time, better enforcement tools will not ensure equity if the regulatory standards related to scope of coverage and NQTL comparability determinations are not resolved.

III. REGULATORY CONUNDRUMS AND UNRESOLVED STANDARDS

Notwithstanding the far-reaching potential of the Parity Act, equity for mental health/substance use disorder care will not be achieved if a restrictive interpretation of the “scope of services” prevails, or if the NQTL “comparability” standard remains an elusive concept that cannot be operationalized. As described in this part, the statutory language and legislative history of the Parity Act hold the answer to the scope-of-services interpretation, even though the IFR suggests otherwise. Clarification of the comparability standard awaits final regulatory

²³⁹ For potential barriers to receiving that assistance, *see* Harmon, *supra* note 204, at 451 (noting that some healthcare providers may not want to risk alienating health plans with repeated claims or invest the time in rebutting a plan’s denial; legal community has little incentive to pursue external appeals because attorney’s fees under ERISA are limited to fees incurred after litigation commences).

²⁴⁰ Both the insurance industry and consumer advocates have raised concerns about the ability of IROs to resolve disputes related to NQTLs. MBHOs objected to the application of the federal external review standards to NQTLs, noting that independent review organizations are not qualified to undertake the required analysis and issue a determination on plan provisions or benefit design or criteria. *See, e.g.*, Letter from Teresa Berman, *supra* note 235, at 6. Parity advocates, on the other hand, sought a final rule that required “reviews and decisions based on medical necessity and appropriateness . . . [to be] conducted by an individual with the appropriate medical and clinical education and training that meets or exceeds the education and credentialing of the treating provider in the field at issue, and who is currently in active practice and credentialed in the particular field at issue.” Letter from Parity Implementation Coal. to Dep’ts of Labor, Health & Human Servs., & Treasury 8 (July 25, 2011), *available at* www.dol.gov/ebsa/pdf/98-2719-IFR.pdf.

²⁴¹ Harmon, *supra* note 204, at 452, 453-54 (critiquing the federal external review regulation that allows plans governed by the federal external review process to select among at least three contracted IROs for external review, whereas state external review laws prohibit IRO selection by the plan, individual, or insurance issuer).

guidance, but the underlying principles for enforcement have been formulated in sub-regulatory guidance. The NQTL comparability standards rely on the interpretive approach adopted under other civil rights statutes that also apply a comparability standard to evaluate discrimination in health benefits as well as health care and benefit design practices.

A. “SCOPE OF SERVICES” STANDARD UNDER THE PARITY ACT

The statutory right of health plans to exclude coverage altogether for mental health or substance use disorder benefits raises the related questions of (1) whether a plan that covers these benefits may restrict the services that are offered, and if so, (2) the standard for evaluating whether such a restriction complies with the Parity Act. The answer is key to whether an individual with an addiction problem will have access to a full continuum of services that may be needed to treat his or her condition, equivalent to the services a person who is receiving cardiac care may access—including medications, outpatient counseling of varying degrees of intensity, inpatient hospital care, and residential rehabilitation—or a bare minimum of treatment that the plan is given total discretion to define.²⁴² Although the Parity Act’s language, legislative history, and certain regulatory standards would indicate this is a closed question, the regulatory agencies assert otherwise. The agencies’ IFR preamble explains that the regulation does not address the scope of services, even though it acknowledges that the law itself prohibits health plans from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than those applied to medical benefits.²⁴³

Resolution of this issue is a linchpin to achieving equity and therefore merits a detailed analysis of the Parity Act’s legislative history and regulations to inform further agency action and judicial review. The interplay of three portions of the statute—the definitions of key terms, the non-discrimination standard for treatment limitations, and the authority of a plan to exclude mental health or substance use disorder benefits—must be examined by a court addressing this question.

²⁴² See, e.g., Parity Implementation Coal. to EBSA Supervisory Benefit Advisor, U.S. Dep’t of Labor, Atlanta, Ga. (June 23, 2011) (complaint against Coca-Cola Bottling Co. United) (on file with author); Parity Implementation Coal. to EBSA Supervisory Benefit Advisor, U.S. Dep’t of Labor, Fort Wright, Ky. (June 23, 2011) (complaint against Papa John’s Int’l, Inc.) (on file with author).

²⁴³ Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5416 (Feb. 2, 2010). The Departments invited comments on whether and to what extent the parity law addresses the scope of services or continuum of care provided. *Id.* at 5416-17.

1. “Benefits” Are Services

The first question is whether mental health and substance use disorder “benefits”—the term used in the law—encompasses “services” themselves. The statutory definitions of “medical or surgical benefits,” “mental health or substance use disorder benefits,” and “substance use disorder benefits” support a conclusion that “benefits” are the “services” that will be covered and reimbursed. Each of these terms is defined as “benefits with respect to services.” The term “medical or surgical benefits” is defined with a singular focus on services: “benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage”²⁴⁴ Mental health or substance use disorder benefits are defined as “benefits with respect to services for mental health conditions [or substance use disorders], as defined under the terms of the plan and in accordance with applicable Federal and State law.”²⁴⁵ Thus, a “benefit”—regardless of whether medical, surgical, mental health, or substance use disorder treatment—cannot be construed as anything but the “services” (or therapeutic interventions) themselves.²⁴⁶ This construction is consistent with the Parity Act’s legislative history²⁴⁷ and the widely accepted construction of the term “benefit” in health care law.²⁴⁸

A second statutory standard that informs the meaning of “benefit”—again confirming that Congress had “services” in mind when using this term—is the Parity Act’s definition of “treatment limitations.”²⁴⁹ As described in Part II, the Parity Act provides that “treatment limitations applicable to such mental health or substance use disorder benefits” may be no more restrictive than or separate from the treatment limitations

²⁴⁴ 29 U.S.C.A. § 1185a(e)(3) (Westlaw 2012).

²⁴⁵ *Id.* § 1185a(e)(4), (5).

²⁴⁶ See U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 121, at 5 n.10 (“Benefits are provisions or services included in a health insurance plan’s coverage.”).

²⁴⁷ The House-passed parity bill, H.R. 1424, set out five categories of care to which treatment limitations and financial requirements are applied, which are now identified through regulation in the six classifications. Each of those categories is described as covering the “items and services” provided on either an outpatient, inpatient, or emergency care basis. See H.R. 1424, 110th Cong. §§ 102(a), 103(a), 104(a) (2008). The Senate-passed bill defined “mental health benefits” as “benefits with respect to mental health services (including substance use disorder treatment).” S. 558, 110th Cong. § 2 (2007) (amending section 712A(f) of ERISA).

²⁴⁸ The Institute of Medicine’s study of the essential health benefit defined “covered benefits” as “[t]he medical care items or *services* obtained by a subscriber that a health insurance plan agrees to pay for, under certain terms and limitations.” INST. OF MED., *supra* note 123, at 26 (emphasis added).

²⁴⁹ “The term ‘treatment limitation’ includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limitations on the scope or duration of treatment.” 29 U.S.C.A. § 1185a(a)(3)(B)(iii) (Westlaw 2012).

applied to medical benefits. Treatment limitations would have no purpose in the statute if the frequency, days, or number of visits of treatment applied to the “benefit” did not relate to services themselves. The definition of this term also confirms that Congress intended to regulate the “scope” of treatment services as a “treatment limitation,” because it defines that term to explicitly include “other similar limits *on the scope* or duration of treatment.”²⁵⁰

2. Plan Authority To Limit “Scope of Services”

The second critical question relates to whether the health plan can limit the “scope of services” in any way. The definition of “medical or surgical benefits” indicates that the plan itself defines the services to be covered for all non-mental health and substance use disorders. The same discretion, however, does not extend to mental health and substance use disorders. Instead, the Act’s non-discrimination standard defines the limitations that may be imposed on mental health or substance use disorder services. To place that determination in the hands of the plan without any limitations would amount to the pre-Act status quo. On the other hand, to assert that a plan cannot limit the services for mental health or addiction care in any way would arguably afford broader care coverage than the plan extends to other medical conditions. Congress struck a balance with the non-discrimination standard: it gave the health plan full discretion to shape its medical services and then restricted its choices for mental health or substance use disorder services to those that are “no more restrictive than” or “separate” from standards for the medical benefit.²⁵¹

Insurance carriers reject this formulation, contending that the broad statutory authority to exclude coverage for all mental health or substance use disorder benefits means that their choice on scope of treatment services is also unconstrained. In other words, the greater power includes the lesser power to selectively cover services. Plans rely on Congress’s rejection of the House-passed bill’s provision that would have required coverage of all conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders*²⁵² as further evidence of congressional support for full discretion in identifying the scope of services. The definition of the mental health and substance use disorder benefits also cedes some authority to the carriers, insofar as it states that “services for mental health conditions [or substance use disorders], [are]

²⁵⁰ *Id.* (emphasis added).

²⁵¹ *See id.* § 1185a(b).

²⁵² *See* discussion *supra* accompanying notes 115-118.

as defined under the terms of the plan and in accordance with applicable Federal and State law.”²⁵³ Finally, plans also narrowly construe the “scope of” treatment language in the “treatment limitation” definition, interpreting “other similar limits” to mean other *numerical* limitations on scope of treatment rather than other criteria that limit the continuum of care.²⁵⁴ Thus, plans contend that their choice is limited only by state laws that mandate the coverage of certain behavioral health services and conditions and applicable federal law, which arguably excludes the Parity Act for these purposes to avoid a tautology.

Several statutory standards cast significant doubt on this narrow interpretation. First, a close reading of the definition of the terms “mental health” and “substance use disorder benefits” demonstrates that the phrase “as defined by the terms of the plan” modifies the word “conditions” or “disorders” that may be covered, not the word “services.”²⁵⁵ This is consistent with the Parity Act provision that allows health plans full discretion to define the medical conditions, if any, that are covered. Second, the law’s construction provision identifies the constraints that exist on plans that offer mental health and substance use disorder benefits: it states that plans may set any “terms and conditions of . . . coverage” as long as the terms conform to the non-discrimination standard established by the Parity Act.²⁵⁶ Any limitation on the “scope

²⁵³ 29 U.S.C.A. § 1185a(e)(4), (5) (Westlaw 2012) (emphasis added).

²⁵⁴ Although the term “similar” could be read to reach only those unlisted features that are “quantifiable” in nature, the term “scope,” unlike “duration,” is not amenable to numerical limitations.

²⁵⁵ The importance of this distinction becomes clear after examining the definition of mental health and substance use disorder benefits in both the House- and Senate-passed bills. The definition in the Senate-passed bill did not include the word “conditions” and would be construed correctly to give plans discretion to identify the services to be covered, except as defined in state law. S. 558, 110th Cong. §§ 712A, 2705A (2007) (“The term ‘mental health benefits’ means benefits with respect to mental health services (including substance use disorder treatment) as defined under the terms of the group health plan or coverage, and when applicable as may be defined under State law . . .”). The Senate Report interpreted this provision to mean that “the bill would not . . . require that those plans cover all types of mental health services or ailments if the plan covered any mental health services or ailments. Laws in some States, however, require that plans cover those benefits . . .” S. REP. NO. 110-53, at 7 (2007). The Parity Act, however, adopted the House-passed bill definitions of mental health and substance use disorder benefits, with minor modifications. Those definitions made clear that the word “conditions” and “disorders,” as opposed to “services,” were modified by the phrase “as defined under the terms of the plan.” H.R. 1424, 110th Cong. § 102(b)(4), (5) (2007). (“The term ‘mental health benefits’ mean[s] benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable law, but does not include substance-related disorder benefits. . . . The term ‘substance-related disorder benefits’ means benefits with respect to services for substance-related disorders, as defined under the terms of the plan and in accordance with law.”).

²⁵⁶ 29 U.S.C.A. § 1185a(b)(2) (Westlaw 2012) (“Nothing in this section shall be construed . . . (2) in the case of a group health plan . . . that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under

of service” is certainly a term or condition of coverage, and it is either permitted or disallowed, depending upon whether it is more restrictive than the standard applied to substantially all medical benefits.

A restrictive interpretation of “scope of services” is also at odds with several standards the IFR establishes to determine parity compliance. First, the IFR provides six categories of services that serve as the basis for comparisons between medical benefits and mental health and substance use disorder services. By so doing, the IFR implicitly establishes a “scope of services,” requiring, for example, the provision of outpatient, inpatient, and emergency care, and prescription drugs whenever any mental health or addiction benefit is provided in any one of these classifications so long as a medical benefit is provided in the classification. “Cross-classification” parity is required, according to the regulating agencies, because the failure to offer an addiction benefit in the same categories in which medical care is provided is “a limit . . . on the type of setting or context in which treatment is offered.”²⁵⁷ The same must be true if medical services of a particular type or intensity are offered within a classification but comparable addiction services are not; i.e., the *type* of care is limited, not just the setting or context.

Second, the IFR explicitly addresses “a variety of limits [imposed by plans] affecting the scope and duration of benefits under the plan that are not expressed numerically”²⁵⁸ by barring discrimination in the use of non-quantitative treatment limitations. Restrictions on the scope of addiction services amount to an NQTL. In other words, a plan implements a rule that disallows certain services required to treat a person’s opiate addiction, while not limiting the continuum of services required to treat a patient’s heart disease.²⁵⁹ If the law authorizes the regulation of a wide range of plan design features (medical management, provider network design and reimbursement rates, and prescription drug formularies) because they affect the “scope” of benefits, then certainly any plan feature that directly limits the scope of services to one type of care for a condition should be within the law’s purview. Members of Congress have noted their disapproval of the IFR’s failure to address the scope-of-services standard, informing the regulatory agencies that the Parity Act was intended to require equity in the scope of services offered

the plan or coverage, except as provided in subsection (a).”). The internal reference to the parity law standard in the construction provision makes it unnecessary to determine whether the reference to “federal law” in the definition of mental health and substance use disorder also encompasses the parity law.

²⁵⁷ Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5413 (Feb. 2, 2010).

²⁵⁸ *Id.* at 5416.

²⁵⁹ See Letter from Patton Boggs LLP to Parity Implementation Coal. 4-5 (Mar. 26, 2010).

as long as a mental health or substance use disorder condition is covered.²⁶⁰

3. *Clinical Practice Standards Related to “Scope of Services”*

To the extent a plan’s restriction on the scope of services is deemed to be an NQTL that is not applied to medical benefits, that restriction is only permitted if “recognized clinically appropriate standards of care . . . permit a difference.”²⁶¹ Plans would be hard-pressed to meet that standard in light of current clinical practice standards for addiction treatment. For example, the National Quality Forum (NQF), a nonprofit organization that develops national consensus standards to improve the quality of healthcare, has identified evidence-based standards for substance use disorder treatment that include a full continuum of care from identification of a substance use problem by a general health practitioner to treatment for substance use illness in general medical, mental health, and specialty settings.²⁶² Appropriate treatment services include withdrawal management, psychosocial treatment in inpatient and outpatient settings as well as mental health and general medical settings, pharmacotherapy linked with psychosocial treatment, and continuing care management.²⁶³ The NQF standards also state that an appropriate “dose” of treatment is required for treatment effectiveness and relies on research to suggest that most patients require about three months of treatment to reach a threshold of significant improvement and then additional care or support for sustained recovery.²⁶⁴

²⁶⁰ Letter from Paul D. Tonko, Member of Congress, et al. to Hilda Solis, U.S. Labor Sec’y, Timothy Geithner, U.S. Treasury Sec’y, and Kathleen Sebelius, U.S. Health & Human Servs. Sec’y (May 18, 2011) (“Let us be unequivocal—while the MPHAEA was never intended to be a mandate for coverage of specific mental health conditions or addictive disorders—once a plan has chosen to provide coverage for a specific mental health or substance use disorder, the basic framework of the law is to equalize behavioral and medical benefits and end the discrimination that has for so long limited access to behavioral benefits, as compared to the medical benefits covered by plans. Plan participant and beneficiary access to a similar scope of services and continuum of care on the behavioral health side as is provided on the medical side was clearly an integral part of the MPHAEA.”) (on file with author); *see also* Al Franken, U.S. Senator, et al. to Hilda Solis, U.S. Labor Sec’y, Timothy Geithner, U.S. Treasury Sec’y, and Kathleen Sebelius, U.S. Health & Human Servs. Sec’y (May 12, 2011) (“The regulations themselves confer a scope of service by requiring that plans cover a minimum of six types of services.”) (on file with author).

²⁶¹ 26 C.F.R. § 54.9812-1T(c)(4)(i) (Westlaw 2013); 29 C.F.R. § 2590.712(c)(4)(i) (Westlaw 2013); 45 C.F.R. § 146.136(c)(4)(i) (Westlaw 2013).

²⁶² NAT’L QUALITY FORUM, NAT’L VOLUNTARY CONSENSUS STANDARDS FOR THE TREATMENT OF SUBSTANCE USE CONDITIONS: EVIDENCE-BASED TREATMENT PRACTICES 14-24 (2007).

²⁶³ *Id.*

²⁶⁴ *Id.* at 18-19 (citing NIDA, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE (1999)).

The American Society of Addiction Medicine (ASAM) has developed a national standard—used by over thirty states²⁶⁵—to evaluate the appropriate level of care for patients with substance use disorders and to assist care providers and managed care companies in establishing care standards. The ASAM Patient Placement Criteria identify five different levels of addiction treatment that a patient may require, depending upon the severity of her or his condition: early intervention, outpatient services, intensive outpatient/partial hospitalization, residential/inpatient (including four different levels of non-hospital residential care), and medically managed intensive inpatient services.²⁶⁶ The specialty care settings in which services are provided across this continuum are often accredited by the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF)²⁶⁷—the national accrediting bodies that accredit medical and surgical facilities.

Nationally recognized care guidelines, the Milliman Care Guidelines,²⁶⁸ like the ASAM criteria, also provide for a full continuum of behavioral health services based on best practices in the medical and scientific literature. According to a Milliman analysis of the behavioral health services required to treat depression and alcoholism, care must be available across five levels of care to appropriately address the severity

²⁶⁵ *The ASAM Patient Placement Criteria*, AM. SOC'Y ADDICTION MED., 2-4 (2001) (referencing Levels 0.5, I, II, III, and IV). Maryland, for example, requires addiction treatment programs to adhere to ASAM Placement Criteria when making treatment decisions, including care funded under grant funds and Medicaid. MD. CODE REGS. 10.09.67.10(A)(1)(b), 10.47.10.04(A)(2)(a) (Westlaw 2012).

²⁶⁶ ASAM PATIENT PLACEMENT CRITERIA FOR THE TREATMENT OF SUBSTANCE-RELATED DISORDERS 27-33 (David Mee-Lee ed., 2d ed. 2001).

²⁶⁷ CARF, for example, accredits programs that provide medical rehabilitation for conditions such as brain trauma, stroke, cardiac rehabilitation, amputation, and physical injury that parallel the types of programs and services that are required for substance use disorder rehabilitation. Letter from Nikki Migas, Comm'n on Accreditation of Rehab. Facilities Int'l to Dep't of Labor, Ctrs. for Medicare & Medicaid Servs., Office of Disability, Aging, and Long-Term Care Policy, and Substance Abuse & Mental Health Servs. Admin. (Nov. 3, 2010) (on file with author). Each set of conditions may require a period of acute hospitalization followed by a period of residential rehabilitation, periodic services on an outpatient basis, and home and community services. *Id.*

²⁶⁸ The Milliman Care Guidelines are developed to assist clinicians in making evidence-based care decisions in a range of healthcare settings, including hospital, acute and subacute medical and rehabilitation, skilled nursing, home healthcare, and ambulatory facilities. *See* Letter from Stephen P. Melek, Milliman Consulting Actuary, to Carol McDaid, Principal, Capital Decisions, Inc. 3-4 (Dec. 7, 2010). The Guidelines identify a range of “demonstrated best practices” and seek to reduce unnecessary and pervasive variation in medical practice. *Id.* at 4. The Centers for Medicare and Medicaid and some of the largest health plans in the United States use the Milliman Care Guidelines to support their utilization and quality review. *Id.* (stating that “the Parity Implementation Coalition asked us to conduct an analysis of the scope and range of services between common Medical and Behavioral disorders”).

of the patient's condition and recovery progress.²⁶⁹ Those levels of care—acute inpatient hospital care; subacute inpatient care including rehabilitation hospitals, skilled nursing facilities, and other facilities like residential treatment programs; intensive outpatient services; home health services; and routine outpatient care²⁷⁰—are analogous to the levels of care required for the treatment of common medical conditions.

Milliman compared the Care Guidelines for services required to treat diabetes and myocardial infarction with coronary artery disease with those required for alcoholism and depression, respectively, and concluded that the “levels of care and settings for treatment were similar and analogous” and that “many of the clinical criteria, such as judgments about the acuity and severity of the illness, were similar for both medical and behavioral conditions.”²⁷¹ Based on its review, Milliman discourages “differences in the availability of a continuum of care alternatives between common medical and common behavioral conditions” and advises that “access to a complete continuum of evidence-based care alternatives is vital for achieving best practices in care delivery.”²⁷²

Thus, a fair reading of the legal standards and application of clinical practice guidelines suggest that health plans that restrict the continuum of services for mental health or substance use disorder care while providing a full spectrum of service levels to treat medical conditions violate the Parity Act. This is not to suggest that the specific healthcare services required to treat a person with alcoholism will be the same as those required to treat a person with diabetes—those services are unique to the underlying condition just as they would be unique if one were comparing care for two different “medical” illnesses, such as diabetes and asthma.²⁷³ But if a plan covers acute hospital and subacute residential services in its inpatient classification for common medical conditions, it must do the same for a substance use disorder once the plan includes that condition.²⁷⁴

²⁶⁹ This analysis, performed at the request of the Parity Implementation Coalition to respond to the IFR request for information on the scope of service issue, compared the scope and range of services under the Milliman Care Guidelines for three common behavioral health disorders with three medical disorders. Letter from Stephen P. Melek, *supra* note 268, at 1.

²⁷⁰ *Id.*

²⁷¹ *Id.* at 2.

²⁷² *Id.* at 2-3.

²⁷³ *Id.* at 2.

²⁷⁴ This construction of the Parity Act's scope of services standard conforms with the Title VII gender discrimination standard for health insurance coverage, as set out in *Newport News Shipbuilding and Dry Dock Co. v. EEOC*, 462 U.S. 669, 685 (1983) (holding that health insurance benefits for pregnancy-related conditions that provide more comprehensive services for female employees than for the wives of male employees violate Title VII). The Title VII standard has been

A recent HHS analysis of scope of services seems to reflect a greater concern about whether a robust scope-of-services requirement would deviate from current employer-based plan coverage (and thereby impose significant additional plan costs) than about whether the legal authority exists to require parity for scope of services. Research, in fact, reveals that employer health plans in 2008 (pre-parity) covered “intermediate” levels of care for mental health/substance use disorders (those lying between inpatient and outpatient) to significant, but varying, degrees. Virtually all employer plans (98%) had claims for intensive outpatient treatment; over half (59%) had claims for partial hospitalization; and one fifth (18%) had claims for non-hospital residential treatment.²⁷⁵ The additional cost to the plan of providing these three services represented a “very small fraction of the average total plan cost.”²⁷⁶ Thus, statutory interpretation, clinical practice, and cost considerations support a determination that a plan’s scope of services for behavioral health services must be comparable to medical services.

B. NON-QUANTITATIVE TREATMENT LIMITATIONS: IMPLEMENTING THE COMPARABILITY STANDARD

The IFR standard for non-quantitative treatment limitations offers limited guidance for enforcement of this important and far-reaching standard. The regulatory agencies have begun to fill the gap with workable standards, but they must be placed in final regulations to eliminate confusion about the standard and ensure consistent application. The emerging compliance test is based on the principle that plan administrators are barred from managing mental health/substance use

delineated most extensively in the Pregnancy Discrimination Act (PDA) benefits context in which the EEOC looks to comparable non-pregnancy related medical service categories and compares the scope of services available for pregnancy care. See 29 C.F.R. Pt. 1604, App. (Westlaw 2013) (Questions 3, 21-29 and Answers). EEOC guidance, for example, evaluates the legality of a policy’s exclusion of routine sonograms during the course of pregnancy by comparing it to the policy’s coverage of other routine diagnostic procedures. If the employer’s policy covers routine dental x-rays or PAP smears, the EEOC has concluded that it must cover sonograms to a comparable extent. EEOC, *supra* note 133. Similarly, the EEOC has advised that a plan must cover the cost of a private hospital room for pregnancy-related conditions if it does so for other medical conditions; it must also cover the cost of pre- and post-natal office visits if it covers office visits to physicians for other medical conditions. 29 C.F.R. Pt. 1604, App. (Question 25). This same analytical approach should apply under the Parity Act and regulations to effectuate the explicit policy of ensuring that behavioral health benefits are not distinguished from medical/surgical benefits. See Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5415 (Feb. 2, 2010).

²⁷⁵ U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 233, at 30.

²⁷⁶ *Id.* (\$2.40 per member per month, or 0.9%).

disorder services differently from medical services unless a clinical justification exists. As described below, plan administrators must follow a three-step process to demonstrate that the underlying factors the plan uses to apply NQTLs are comparable and, thus, parity compliant.

As described in Part II.B, the IFR defines NQTLs as a type of “treatment limitation”²⁷⁷ but adopts a standard that requires a comparison of the underlying NQTL “processes, strategies, evidentiary standards, or other factors” both as written and as applied to behavioral health and medical services in the particular classification. This standard fits within a classic equality framework in which the NQTL standards for the “protected class”—mental health and substance use disorder benefits—are compared to the NQTL standards of the control group—medical benefits in the same classification.

The NQTL standard poses implementation challenges for at least two interrelated reasons.²⁷⁸ First, the term “comparable” is not defined in the regulations.²⁷⁹ In other discrimination contexts, the term “comparable” means “similar to”²⁸⁰ or possessing “important common

²⁷⁷ Some legal interpretations assert that the “substantially all” and “predominant” standards also apply to NQTLs specifically because they are a form of treatment limitations. See Letter from Patton Boggs LLP to Parity Implementation Coal. 10-13 (Mar. 26, 2010) (on file with author). Under this interpretation, an NQTL must first satisfy the “substantially all” standard of applying to two thirds of the medical benefits. *Id.* at 10. The “comparable to/applied no more stringently” standard is then applied as the measure of whether an NQTL is “more restrictive” than the standard applied to medical benefits, since there is no quantitative measure to evaluate the degree of restrictiveness. *Id.* at 11. This analysis concedes that the language and structure of the IFR do not necessarily support this interpretation. *Id.* at 12. Although DOL’s November 2011 sub-regulatory guidance construes the validity of NQTLs through the treatment limitation framework of barring “separate” or “more restrictive” standards, it makes clear that an arithmetic test does not apply to the NQTL parity analysis. *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, *supra* note 133.

²⁷⁸ U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 121, at 18-19 (noting that the IFR does not specify steps employers can use to comply with the NQTL standards and that the “comparable” and “no more stringently” terms may be interpreted and applied inconsistently, which MBHOs have acknowledged they are doing).

²⁷⁹ The Merriam-Webster dictionary definition of “comparable” is “capable of or suitable for comparison.” MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 252 (11th ed. 2007). This provides a qualitative standard that offers limited guidance for purposes of implementation in the Parity Act context, because the comparator is the full range of medical benefits.

²⁸⁰ For example, the Pregnancy Discrimination Act affords a pregnant woman a comparative right to workplace accommodations that is defined by the standards set for all other employees with a similar capacity to work. 42 U.S.C.A. § 2000e(k) (Westlaw 2012) (“[W]omen affected by pregnancy, childbirth or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but *similar* in their ability or inability to work . . .” (emphasis added)). For a discussion of this standard, see Joanna L. Grossman, *Pregnancy, Work and the Promise of Equal Citizenship*, 98 GEO. L.J. 567, 613-15 (2010). In addition, some state Equal Pay Act provisions establish a standard that looks to whether the work is of a “comparable” character. See Deborah Thompson Eisenberg, *Shattering the Equal Pay Act’s Glass Ceiling*, 63 SMU L. REV. 17, 46-47 (2010) (explaining that

characteristics,”²⁸¹ and the identification of a comparison group or one member of the comparison group who is afforded more favorable treatment would render the challenged practice invalid. Disputes may exist over whether one comparator is more closely aligned with the protected group than another comparator,²⁸² but a fairly well-defined and limited range of choices generally exists,²⁸³ and a careful analysis of the facts will allow a determination of which comparator is most like the protected group.²⁸⁴

In the parity context, however, the regulations identify the appropriate comparator as “medical/surgical benefits,” a category that encompasses a wide range of services for hundreds of conditions. Health plans may identify a single medical service in the classification that is subject to the same NQTL as behavioral health services, thereby justifying the standard, regardless of the number of medical services for which no such requirement exists. Or, as the industry has asserted, certain behavioral health services have no analogue in medical care, and thus no comparison can be made. With limited guidance in the IFR as to what is sufficient for comparison purposes, a court would have to exercise considerable discretion in resolving the dispute.²⁸⁵

Oregon’s standard of “work of comparable character” has been interpreted to mean a job “substantially similar” to that performed by male supervisors). My thanks to Professor Deborah Eisenberg for directing my analysis to these sets of standards.

²⁸¹ Bureau of Labor & Indus. v. City of Roseburg, 706 P.2d 956, 959 n.2 (Or. Ct. App. 1985).

²⁸² In the Fair Housing Act context, for example, a group recovery home for persons with histories of alcoholism or drug dependence that challenges a restrictive zoning or fire safety standard must often demonstrate its similarity to one land use classification (a single family dwelling) as opposed to another (a rooming or boarding house), based on the functional relationship of the residents and the dwelling. See, e.g., Tsombanidis v. City of W. Haven, 180 F. Supp. 2d 262, 284 (D. Conn. 2001) (finding that a group recovery home is a single-family house for purposes of zoning, not a lodging or boarding house), *aff’d in part, rev’d in part*, 352 F.3d 565 (2d Cir. 2003).

²⁸³ For example, in a pending discrimination case related to zoning standards for residential drug treatment programs, in which I am counsel, the parties narrowed the comparators to single and multiple family dwellings, hospitals, nursing homes, and community correctional facilities, but disagreed on the “right” comparator. The court adopted the comparator that the City defendant had asserted, without explaining the basis of its decision. See *United States v. City of Balt.*, 845 F. Supp. 2d 640, 650 (D. Md. 2012). In the pregnancy discrimination context, some commentators have observed that “comparators” are, in fact, difficult to identify, undermining the ability to demonstrate that an employer’s failure to accommodate a pregnant woman’s request for job modifications deviates from accommodations afforded non-pregnant employees. See Grossman, *supra* note 280, at 614-15.

²⁸⁴ See, e.g., *Hovsons, Inc. v. Twp. of Brick*, 89 F.3d 1096, 1104-05 (3d Cir. 1996) (comparing zoning standards for a nursing home with those for a residential retirement community, both of which cater to elderly people); *Smith Berch, Inc. v. Balt. Cnty.*, 115 F. Supp. 2d 520, 523-24 (D. Md. 2000) (comparing zoning standards for methadone treatment program with those of other medical clinics and treatment programs).

²⁸⁵ Courts may also gloss over the exact parameters of the comparable medical standard. One commentator has critiqued the court’s decision in *Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001), which invalidated the exclusion of prescription contraceptives based on

Second, and closely related, the medical services across the spectrum of those “medical/surgical benefits” are condition-specific, rendering them difficult to compare or evaluate on a “stringency” scale.²⁸⁶ Insurance carriers and MBHOs have complained that it is impossible to conduct an “apples-to-apples” comparison, considering the wide variation in the benefits themselves.²⁸⁷ Although NQTLs are best thought of as generalizable standards that functionally affect access to care—as opposed to the medical guidelines for treating a particular condition—the IFRs “safe harbor” standard lends credence to the suggestion that “clinical standards of care” for particular conditions may be a part of this analysis.²⁸⁸ These concerns suggest the more fundamental question of whether a discrimination framework—and particularly one that focuses on disparate treatment—is even the right paradigm.

Sub-regulatory guidance suggests that a micro-level inquiry or a “mapping” of medical benefits onto behavioral health benefits is neither the right starting point nor the appropriate focus of the equity analysis. Instead, the regulatory agencies set out a three-step process that first requires the plan to identify the underlying “factors” that govern the plan

the lack of comprehensive coverage of women’s prescription drugs compared with the formulary for men, for failing to identify the comparable drugs that were covered for men. Hoffman, *supra* note 25, at 1351.

²⁸⁶ Thus, in contrast to the “scope of services” issue where the same levels of services are generally required to provide appropriate care for both medical and addiction/mental health disorders, once one goes beyond the framework of those levels of care, the individual services will differ depending upon the medical condition, whether that is a somatic condition or a mental health/substance use condition.

²⁸⁷ See *supra* note 166 (plaintiff’s complaint in *Coalition for Parity, Inc. v. Sebelius* alleged that “medical and behavioral health benefits cannot be compared on an ‘apples to apples’ basis”). The National Committee for Quality Assurance (NCQA), which set standards for and accredits health plans, has observed that there is no practical way to compare whether a single coverage decision is arrived at in a manner that is more restrictive than a corresponding medical determination. Letter from Margaret E. O’Kane, President, Nat’l Comm. for Quality Assurance, to Kathleen Sebelius, U.S. Health & Human Servs. Sec’y, Hilda Solis, U.S. Labor Sec’y, and Timothy Geithner, U.S. Treasury Sec’y (May 3, 2010), available at www.dol.gov/ebsa/pdf/1210-AB30-5314.pdf. As an alternative to the IFR standard, the NCQA recommends that the safe harbor be extended to protect plans that meet certain procedural guidelines, which, according to NCQA, would ensure that NQTLs are applied in an evidence-based manner rather than in a way to limit mental health and substance use disorder care. Among those procedural safeguards are a documented utilization review process that is administered by mental health practitioners; coverage decisions that are objective, based on clinical evidence and applied consistently; and decisions that are rendered in a timely manner with a right to appeal. *Id.* This formulation does not, however, add anything to the procedural standards that should already govern medical management practices.

²⁸⁸ The IFR preamble acknowledged that condition-level considerations are implicated in the comparability standard, noting that different types of injuries or illnesses may require different review and different care. Interim Final Rules Under Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5416 (Feb. 2, 2010) (“The acute versus chronic nature of a condition, the complexity of it or the treatment involved, and other factors may affect the review.”).

administrator's decisionmaking when applying an NQTL across all health benefits (both behavioral and medical benefits).²⁸⁹ Identification of the processes by which those factors have been developed is also relevant to the determination of whether the comparability requirement has been satisfied.²⁹⁰ Second, the underlying factors that apply to behavioral health benefits and the processes used to arrive at those factors must be compared for evidence of "arbitrary or discriminatory differences."²⁹¹ Third, the plan must justify any variation in the standards for mental health/substance use disorders by documenting its reliance on a clinically appropriate standard of care.²⁹² Just as an employer must identify the essential functions of a job to facilitate a fair evaluation of whether an individual with a disability is qualified for or has been unlawfully rejected from the position,²⁹³ so must an employer's health plan administrator "document[] its analysis that its NQTL processes and strategies . . . are comparable across medical/surgical and mental health/substance use disorder benefits."²⁹⁴

The regulatory agencies have identified relevant industry-based factors that plans may use in designing their NQTLs and the framework for a fair rule-setting process.²⁹⁵ Generally, plans should adopt their "rules" through a review of the medical literature, professional standards and protocols, and other empirical data that may be specific to the

²⁸⁹ This analysis is most clearly set out in the DOL's Self-Compliance Tool for Part 7 of ERISA. U.S. DEP'T OF LABOR, *supra* note 173, at 27-29.

²⁹⁰ For example, an HHS analysis of the comparability standard as applied to medical necessity criteria focused on whether the *process* for establishing and updating the criteria for mental health/substance use disorder benefits and medical benefits was comparable as well as the medical necessity criteria themselves. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 233, at 9-10.

²⁹¹ See U.S. DEP'T OF LABOR, *supra* note 173, at 28.

²⁹² *Id.* at 28-29 (explaining that a plan's decision to cover neuropsychological testing for only certain behavioral health conditions must be based on documented criteria and evidence supporting its decision, and the requirement that behavioral health providers have supervised clinical training to participate in network is permissible even if a similar requirement does not exist for medical practitioners, because the latter professionals satisfy supervised clinical training requirement as a degree requirement). As an additional example, an HHS analysis concluded that a "stepped care requirement" that routinely requires a person with substance use disorder to participate in outpatient treatment before being authorized for inpatient or residential treatment would be inequitable because such requirements are not applied routinely to general medical conditions. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 233, at 11.

²⁹³ See 29 C.F.R. § 1630.2(m), (n)(3)(ii) (Westlaw 2013) (defining "qualified" as an individual who meets the job-related requirements and can perform the essential functions of the position, with or without reasonable accommodations; and evidence of whether particular function is "essential" to include "written job descriptions prepared before advertising or interviewing applicants for the job").

²⁹⁴ See U.S. DEP'T OF LABOR, *supra* note 173, at 28.

²⁹⁵ The regulatory agencies relied on an industry and expert consultation process to develop these standards. See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 233, at 4, 9 (explaining the process).

plan.²⁹⁶ Reliance on evidence-based resources should prevent selection of arbitrary or discriminatory standards. Factors that may be taken into consideration when deciding whether to apply an NQTL include the cost of treatment, high-cost growth, variability in cost and quality, elasticity of demand, provider discretion in determining diagnosis or type or length of treatment, clinical efficacy of proposed treatment, licensing and accreditation of providers, and types of claims with a high percentage of fraud.²⁹⁷ Many of these considerations reflect MBHO justifications for applying different standards for the management of behavioral health benefits, such as variations in provider training and credentialing, diagnostic uncertainty, variability in duration of treatment, and cost-containment.²⁹⁸ But, as medical experts have pointed out, this variability and uncertainty exist in the treatment of certain medical conditions,²⁹⁹ and thus plans must show that these factors are considered when determining the management features for medical benefits as well.³⁰⁰ The Parity Act is not violated as long as plan administrators apply the relevant factors across both medical and behavioral health benefits in determining which NQTL standard to apply and do not apply the specific NQTL more stringently to behavioral health conditions.

The regulatory agencies have also addressed (at least partially) the concerns of parity advocates that a numerical threshold is needed to demonstrate equality for each NQTL, as with quantifiable treatment limitations and financial requirements. They have built in a rough qualitative check as a proxy for a bright-line standard; the NQTL must apply in a differentiated fashion to both behavioral health and medical benefits. A standard that applies to *all* mental health/substance use

²⁹⁶ See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 233, at 9; *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, *supra* note 133 (approving a plan's medical management techniques that were based, in part, on a "wide array of recognized medical literature and professional standards and protocols").

²⁹⁷ U.S. DEP'T OF LABOR, *supra* note 173, at 27; *FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation*, *supra* note 133.

²⁹⁸ See discussion *supra* accompanying notes 61-69.

²⁹⁹ See U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 233, at 13-14 (explaining that (1) certain medical care procedures are characterized by clinical uncertainty and practice variability, such as physical therapy; (2) certain medical conditions, such as lower back pain, are subject to diagnostic uncertainty and high variability in treatment/provider choice; and (3) practitioners in certain areas of medical care have different levels of medical training, such as surgeons and podiatrists, who provide foot care; physicians, anesthesiologists, and acupuncturists, who do pain management; and psychiatrists, physical therapists, and occupational therapists, who work in physical medicine).

³⁰⁰ For example, a preauthorization requirement for Suboxone, which is used to treat opiate dependence, would be appropriate if justified by clinical considerations, such as risk for abuse. But the same criteria must also be applied to other medications that have a risk of abuse, such as Oxycontin. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 233, at 14.

disorder benefits, but just a few medical benefits, would presumably mean that the plan's standards are not being applied equally across the plan's benefits.³⁰¹ This means that a plan's NQTL standard will not evade scrutiny just because the standard also applies to a small number of medical conditions. In addition, a plan will be barred from defining equity by the lowest common denominator, a limitation identified in other discrimination contexts.³⁰²

The NQTL analytical framework responds appropriately to carrier and MBHO concerns that more restrictive benefit management for behavioral health is needed to ensure appropriate and high quality care, that a comparability standard is unworkable because of the inherent differences between behavioral health and general medical care, and that the IFR's regulation of all plan management features exceeds statutory authority. Clearly, the IFR, in keeping with the Parity Act, permits plans to continue to manage their behavioral health benefits and, in fact, take into consideration cost factors that have been the primary impetus for restrictive standards. Quality considerations are not sacrificed so long as a clinical justification exists for a requirement that regulates a behavioral health provider differently than a medical care provider. And finally, the NQTL framework does not contemplate a one-to-one comparison of behavioral health and medical care services themselves. Rather, it compares the underlying "rules" that govern care delivery more generally. Thus, it should not matter that one type of behavioral health care does not have a perfect analogue in the medical care context—what matters is whether the "rules" that set the standards for plan management for all health services apply across the board regardless of the unique services that may exist for either behavioral or medical care. A clinical justification for a different plan management standard may be available for services that are unique to either behavioral health or medical conditions.

The remaining question that has fueled objections to the application of parity standards to plan management features is whether plan costs will skyrocket without unfettered behavioral health management standards. Economic models that could predict the cost implications of parity for NQTLs did not exist when the statute was enacted because the

³⁰¹ See discussion *supra* accompanying notes 177-179.

³⁰² Under the Pregnancy Discrimination Act, for example, which employs a comparative standard for determining appropriate workplace accommodations, the Seventh Circuit wrote, "Employers can treat pregnant women as badly as they treat similarly affected but nonpregnant employees . . ." *Troupe v. May Dep't Stores Co.*, 20 F.3d 734, 738 (7th Cir. 1994); see also *Maldonado v. U.S. Bank*, 186 F.3d 759, 762 (7th Cir. 1999) ("[U]nder the PDA, employers are not required to give pregnant women special treatment; they must only treat them the same as all other employees.").

original Federal Employee Health Benefit Plan (FEHPB) model did not require parity in plan management, and FEHPB plans frequently delivered behavioral health through carve-out arrangements to manage utilization and cost.³⁰³ A recent study of plan costs under Oregon's parity law, one of the few state parity laws that applies to NQTLs as well as financial requirements and quantitative treatment limitations,³⁰⁴ sheds light on this question.

Like the Parity Act, the Oregon law allows plans to manage the behavioral health benefit to control costs and utilization, but disallows differential management of that benefit. In a comparison of the plan costs for four commercial insurance plans in the two years preceding and following the implementation of the Oregon parity law, plan spending increased between \$12 and \$26 per person using behavioral health care, but no spending increase was statistically significant.³⁰⁵ The study authors concluded, based on the Oregon data, that the effect of the federal parity law on overall plan spending could be relatively small, in large part because behavioral health expenditures are a small portion of total plan spending,³⁰⁶ and the services remain a managed benefit.³⁰⁷

The remaining challenge from an implementation perspective is to ensure that health plans comply with the parity standards on a consistent basis.³⁰⁸ Part IV identifies actions on the part of health plan certification bodies, federal regulators, and state insurance departments that will address front-end compliance.

³⁰³ See discussion *supra* accompanying notes 54-57; U.S. Office of Personnel Mgmt., FEHB Program Carrier Letter, No. 2008-17 (Nov. 10, 2008), available at www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf (in announcing additional parity requirements pursuant to the Parity Act, OPM noted that the FEHPB program had been able to expand access by "using managed care programs to ensure access to appropriate provider networks and to keep cost increases to a minimum").

³⁰⁴ OR. REV. STAT. § 743A.168 (Westlaw 2012) (group health insurance policy providing coverage for hospital or medical expenses "shall provide coverage for expenses arising from treatment for chemical dependence, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions"; applying standard to deductibles, coinsurance, treatment limitations, medical necessity determinations, and utilization management).

³⁰⁵ K. John McConnell et al., *Behavioral Health Insurance Parity: Does Oregon's Experience Presage the National Experience with the Mental Health Parity and Addiction Equity Act?*, 169 AM. J. PSYCHIATRY 31, 34 (2012) (reporting the average change in spending for adults after accounting for secular trends; the change in spending for children was higher than adults, but the point estimate of the effect of parity for all individuals across all four plans was \$15).

³⁰⁶ *Id.* at 36.

³⁰⁷ Susan H. Busch, *Implications of the Mental Health Parity and Addiction Equity Act*, 169 AM. J. PSYCHIATRY 1, 2 (2012).

³⁰⁸ McConnell et al., *supra* note 305, at 33 (noting that across the four plans, "compliance and interpretation of the parity law were inconsistent").

IV. STRATEGIES TO ENSURE PLAN COMPLIANCE WITH PARITY REQUIREMENTS

The Parity Act, coupled with the extension of parity protections to persons purchasing individual and small group coverage under the ACA, will go a long way to remedy historical discrimination if enforced on multiple levels. Federal regulators and state insurance commissioners, along with the future Health Benefit Exchanges,³⁰⁹ have the authority to ensure front-end compliance with the Parity Act so that individuals with mental health and substance use disorders need not be the front-line enforcers. National accreditation bodies, such as URAC and the National Committee for Quality Assurance (NCQA), have similar authority regarding carriers that wish to sell group plans, and they play a particularly important role for those entities selling qualified health plans in Health Benefit Exchanges.³¹⁰ Given the long history of discriminatory insurance standards, the complexity of the parity regulations, and the plan's control of information required to monitor compliance, it seems most equitable to require a health plan to demonstrate compliance with the Parity Act as a condition of a carrier's accreditation or plan certification. As described below, some regulatory entities have begun to require this evidence, thereby demonstrating the feasibility of the approach. The following modest recommendations will promote better enforcement without imposing additional costs on group plans and insurance issuers.

A. PROMULGATION OF FINAL PARITY REGULATIONS

Federal regulators must promptly issue a final rule for employer-based group health plans and Medicaid managed care plans to end the uncertainty regarding the Parity Act's application to a plan's scope of services and to achieve more uniform implementation of the plan management (NQTL) standards. The timing is critical because many states are moving forward under the tight ACA implementation schedule to establish certification standards for qualified health plans. The ACA

³⁰⁹ Sections 1311(b) and 1321(b) of the Affordable Care Act require each state to establish a Health Benefit Exchange, which will be the marketplace for the sale of insurance to individuals and small employers, or to participate in a federally established Exchange. Pub. L. No. 111-148, §§ 1311(b), 1321(b), 124 Stat. 119, 173, 186 (2010).

³¹⁰ Section 1311(c)(1)(D)(i) of the Affordable Care Act requires a health plan issuer to be "accredited with respect to local performance on clinical quality measures." Pub. L. No. 111-148, § 1311(c)(1)(D)(i), 124 Stat. 119, 173 (2010). Recently promulgated regulations require qualified health plan issuers to obtain accreditation from either URAC or the National Committee for Quality Assurance (NCQA). 45 C.F.R. § 156.275(b)(1), (2)(i) (Westlaw 2013).

requirement that qualified health plans include coverage of mental health and addiction treatment in the Essential Health Benefits package will protect against benefit exclusion in individual and small group plans and, additionally, will require (separate from the parity requirement) some level of proportionality with the scope of coverage for other required essential health benefits.³¹¹ The application of parity standards to all qualified health plans and plans sold in the individual and small group market makes it all the more important to have clearly articulated “scope of services” and plan management standards in place. Both features speak directly to the comprehensiveness and cost of the behavioral health benefit,³¹² and the parameters will determine whether the benefit is truly non-discriminatory.³¹³

The adoption of several additional notification requirements in the final rule would also assist consumers in understanding their rights under the parity law. First, to supplement the required notification of a carrier’s decision to implement a cost-based exemption from the Parity Act,³¹⁴ the regulatory agencies should require plans to provide “affirmative” notification that informs participants and beneficiaries of their right to comparable coverage of mental health and substance use disorder services.³¹⁵ The DOL should also require each plan to include in its Summary Plan Description (SPD)³¹⁶ three items related to the Parity Act: (1) an explanation of how the plan complies with the parity requirements for financial requirements and treatment limitations; (2) notice of the participant/beneficiary’s right to information about the plan’s criteria for medical necessity determinations; and (3) notice that, for denials of coverage based on medical necessity, the

³¹¹ Pub. L. No. 111-148, § 1302(b)(4)(A), 124 Stat. 119, 164 (2010) (requiring that the “essential health benefits reflect an appropriate balance among categories . . . so that benefits are not unduly weighted toward any category”). This standard offers some assurance that the scope of benefits for mental health/substance use disorders will be proportional to medical benefits, even if federal regulators conclude that the Parity Act itself does not require parity in the scope of services.

³¹² See INST. OF MED., *supra* note 123, at 80, 83 (noting that the two competing goals in establishing the Essential Health Benefits are comprehensiveness and cost).

³¹³ The ACA prohibits the states in crafting the Essential Health Benefits package from making coverage decisions, determining reimbursement rates, or designing benefits in a way that “discriminate against individuals because of their age, disability, or expected length of life.” Pub. L. No. 111-148, § 1302(b)(4)(B), 124 Stat. 119, 164 (2010). Although this benefit discrimination standard has not been fleshed out in regulations, it must, at a minimum, incorporate the parity standards for mental health/substance use disorder benefits.

³¹⁴ 26 U.S.C.A. § 9812(c)(2)(E)(i) (Westlaw 2012); 29 U.S.C.A. § 1185a(c)(2)(E)(i) (Westlaw 2012); 42 U.S.C.A. § 300gg-26(c)(2)(E)(i) (Westlaw 2012).

³¹⁵ See 29 U.S.C.A. § 1185(d) (Westlaw 2012) (requiring notification of restrictions on length of hospitalization related to childbirth); *id.* § 1185b(b) (requiring written notice to inform plan participants and beneficiaries of benefits for mastectomy-related health services).

³¹⁶ 29 U.S.C.A. § 1021(a) (Westlaw 2012); 29 C.F.R. § 2520.102-3 (Westlaw 2012).

participant/beneficiary has a right to access the medical necessity criteria for both the behavioral health benefit at issue and the comparable medical benefit. All three SPD explanations will help translate complex standards into more enforceable rights. In addition, explicit SPD requirements would provide some assurance that plans—particularly those that are self-insured and not subject to oversight by state insurance departments—are paying attention to parity requirements.

Finally, the dissemination of agency decisions on parity complaints would expedite the development of a body of standards and begin to fill in gaps in interpretation. As noted above, a substantial number of complaints have been filed with the DOL, but no public record of the resolution of those complaints exists. As with other areas of civil rights enforcement, agency decisions can be an important source of guidance for compliance and self-enforcement.

B. NATIONAL ACCREDITATION STANDARDS

Carriers generally obtain accreditation from national accrediting bodies to demonstrate the quality of their health insurance products or plans, and the accreditation process provides an ideal opportunity to ensure that plans meet parity standards. One national accreditation body, URAC, has included Parity Act compliance standards in its accreditation protocols as of January 2012. The accreditation standards require an organization to provide a written, detailed analysis for each health benefit plan that demonstrates that it does not apply more restrictive financial requirements or treatment limitations for mental health/substance use disorder services.³¹⁷ If the plan applies a different standard for behavioral health benefits, the URAC standards require the organization to provide the medical or scientific evidence or clinical practice guideline that justifies the standard.³¹⁸ Finally, the accreditation standards require any issuer that contracts with another organization to provide behavioral health benefits, such as a MBHO, to specify that the contractor must comply with the Parity Act.³¹⁹ URAC compliance approval is based on the plan's demonstrated adherence to the designated process and documentation of a reasoned analysis. The key limitation of

³¹⁷ URAC, HEALTH PLAN ACCREDITATION PROGRAM, VERSION 7.0, at 338, 340 (2012) (P-MHP 1—Analysis of Compliance with Mental Health Parity Law—and P-MHP 2 UM—Protocols Applied to MH/SUD Benefits).

³¹⁸ *Id.*

³¹⁹ *Id.* at 342 (P-MHP 3—MH/SUD Parity Addressed in Contractor Written Agreements).

the URAC accreditation standard is that the review body does not “pass judgment” on whether the issuer’s representations are valid.³²⁰

Although URAC accreditation cannot be relied upon as evidence of parity compliance (since no evaluation of plan data is performed), the URAC standard is nonetheless important because it forces organizations to document that an analysis has been done and provide evidence that supports any differential standard for behavioral health care. Adoption of a similar standard by the NCQA is important, at a minimum, to ensure a uniform accreditation standard for the first wave of qualified health plan issuers. The limitations in the URAC standard—its failure to articulate the precise information needed to satisfy the “reasoned analysis” requirement, and its failure to evaluate the evidence of parity compliance—should be addressed in future standards.

C. PLAN DISCLOSURES FOR STATE CERTIFICATION

State insurance departments, as the entities with primary enforcement responsibility over insurance issuers, are uniquely positioned to ensure that health plans offered in their states comply with the Parity Act, including those they must certify as qualified health plans for sale in State Health Benefit Exchanges and the individual and small group commercial markets. The Parity Act prohibits a group health plan or health insurance issuer from selling a plan or policy that does not comply with statutory and regulatory standards.³²¹ Just as state insurance departments verify health plan compliance with other state and federal laws and conduct rate reviews,³²² their plan review should explicitly encompass an examination of parity compliance.

To facilitate that review, health plans should be required to report key data points that are used for a parity compliance evaluation and submit a compliance report. The following data and standards would allow for a complete parity review:

- 1) The standards used to define which services constitute mental health and substance use disorders and which constitute medical/surgical services;

³²⁰ *Id.* at 338.

³²¹ 26 C.F.R. § 54.9812-1T(h) (Westlaw 2013); 29 C.F.R. § 2590.712(h) (Westlaw 2013); 45 C.F.R. § 146.136(h) (Westlaw 2013).

³²² *See, e.g.*, MD. CODE ANN., INS. § 11-206 (Westlaw 2012) (rate filing and review); *id.* §§ 12-203, 12-205 (form filing and approval).

- 2) A list of all mental health and/or substance use disorder benefits (services) that are covered under the plan and those that are excluded from coverage;
- 3) The standards for classifying mental health/substance use disorder benefits and medical benefits as outpatient or inpatient services;
- 4) The source of the plan cost data used to determine the “substantially all” and “predominant” standards for all financial requirements and quantitative treatment limitations, and the relevant values;
- 5) All cumulative financial requirements and treatment limitations and verification that a single value is applied to both behavioral health and medical benefits;
- 6) Annual and lifetime dollar limits that are placed on mental health/substance use disorder benefits and medical benefits;
- 7) All non-quantitative treatment limitations (NQTLs) on health service;
- 8) The processes used to develop each NQTL standard and the factors that are considered in applying the NQTL to behavioral health and medical benefits;
- 9) All clinical guidelines that are relied upon to justify a different NQTL standard for behavioral health benefits;
- 10) Provider reimbursement rates for relevant Current Procedural Terminology (CPT) codes and “usual and customary rates” for services provided by out-of-network providers;
- 11) Standards for participation in provider networks;
- 12) Formulary rules for the coverage of medications used to treat mental health and substance use disorders; and
- 13) The plan’s coverage exclusions.

The administrative cost of providing this information to a state insurance department or other regulatory body would be minimal since the plan should have gathered and evaluated it in preparation for offering the plan.

The presentation of data points is an important addendum to the checklist provided by the DOL Self-Compliance Tool for Part 7 of ERISA.³²³ One of the key barriers to enforcement is access to plan data and information. Placing the essential information in the hands of the state insurance department will provide a repository of information that a

³²³ U.S. DEP’T OF LABOR, *supra* note 173, at 27-29. The tool presents a series of questions that track the regulatory requirements and, thereby, guide the plan through a checklist of items it evaluates. It does, however, emphasize the need to document its NQTL analysis along the lines of the URAC accreditation standard.

plan participant can access if the plan refuses to disclose and that a state consumer assistance unit can use to investigate a complaint expeditiously. At least one state insurance department has required insurance issuers to disclose information to demonstrate parity compliance,³²⁴ and Massachusetts's recently enacted health care reform bill will require all carriers to submit an annual, publicly available report to the state insurance division and Attorney General, outlining how their health benefit plans comply with the Parity Act.³²⁵ Other states must adopt Massachusetts's standard to demonstrate a serious commitment to enforcement.

The Parity Act and regulations effectively root out most “vestiges of structural differences”³²⁶ between behavioral health and medical benefits in health insurance. Regulatory bodies must do much more, however, to ensure that consumers understand their right to equitable health coverage and have access to the information needed to enforce that right. Mandatory demonstrations of parity compliance and disclosures of essential plan information will ensure better health plan compliance and oversight. Vigorous federal agency enforcement commensurate with efforts made under other civil right statutes is also needed to effectuate the Parity Act's remedial goals.

CONCLUSION

National health care policy is moving decisively to integrate mental health and substance use disorder services in mainstream health care. The Affordable Care Act requires the coverage of behavioral health services in the Essential Health Benefits “to remediate what [Congress] saw as shortcomings in current coverage,”³²⁷ and mandates that qualified health plans include within their provider networks sufficient numbers of behavioral health service providers so that care will be accessible without unreasonable delay.³²⁸ The ACA also recognizes the importance of early identification of alcohol and drug use problems by including screening requirements for alcohol misuse as one of the prevention services that primary care practitioners must provide their patients without cost-

³²⁴ See *supra* note 232 regarding Nebraska Insurance Department disclosure form.

³²⁵ S.B. 2400, § 254, 187th Gen. Court, Reg. Sess. (Mass. 2012).

³²⁶ Keith Dixon, *Implementing Mental Health Parity: The Challenge for Health Plans*, 28 HEALTH AFF. 663, 663 (2009).

³²⁷ INST. OF MED., *supra* note 123, at 61.

³²⁸ See 45 C.F.R. § 156.230(a) (Westlaw 2013); *USPSTF A and B Recommendations*, U.S. PREVENTIVE SERVS. TASK FORCE, www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm (last visited Mar. 9, 2013).

sharing.³²⁹ These standards should begin to transform the way the health care system views and provides healthcare for persons with mental health and substance use disorders. They (and their providers) will be a more visible and, over time, less stigmatized population within the healthcare system.

Arguably, comprehensive coverage of behavioral health conditions would never have been adopted under the ACA had advocates not succeeded in winning enactment of the Parity Act. The Parity Act represents the primacy of science over timeworn stereotypes about the origin and disease progression of substance use disorders. Once the patterns of discriminatory insurance coverage were exposed and remedied, it was possible for policymakers to put into place a full range of research-based clinical standards for behavioral health care. The ACA and the Parity Act work synergistically to require the inclusion of behavioral health services on an equal basis with medical services.

The Parity Act and ACA's behavioral health standards respond to fiscal considerations as much as health imperatives. The cost of untreated mental health and substance use disorders to the health care system and employment sector is staggering.³³⁰ As some astute observers of health care delivery in the United States have suggested, providing more and better-coordinated care for those who are the highest consumers of costly health services³³¹ may be the most effective way to reduce our nation's unsustainable level of health care spending.³³²

³²⁹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2713, 124 Stat. 119, 131 (2010).

³³⁰ Carter & Landau, *supra* note 1, at 45 (observing that employers will realize a very strong return on investment by expanding access to mental health services, because mental illness causes more work loss and impairment than many other chronic conditions, including diabetes, arthritis, and asthma; estimating that cost of parity compliance is recouped by preventing one day of absenteeism for an employee with an average salary of \$50,000).

³³¹ See Pamela L. Owens et al., *Mental Health and Substance Abuse-Related Emergency Department Visits Among Adults, 2007*, at 1 (July 2010), available at www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf (reporting that 12 million emergency department (ED) visits in 2007 (12.5 % of all ED visits) involved a diagnosis of a mental health or substance use disorder condition, and nearly 41% of those visits resulted in hospitalization, 2.5 times the rate of hospitalizations for non-mental health/substance use disorder ED visits).

³³² See Atul Gawande, *The Hotspotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?*, NEW YORKER, Jan. 24, 2011, available at www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande (describing the value of consistent, coordinated healthcare and social services to improve the health and reduce hospitalization of an individual with alcohol and cocaine dependence, congestive heart failure, chronic asthma, uncontrolled diabetes, hypothyroidism, gout, and obesity). Stephen Melek, a principal and actuary with Milliman, has advised insurance plans that "providing unlimited behavioral healthcare benefits at lower out-of-pocket costs for members could translate into overall health improvements, which could lead to lower medical/surgical costs for these members over time." Stephen Melek, *Mental Health Parity—Quantitative Treatment Limits*, MILLIMAN BEHAVIORAL HEALTH ADVISOR (Aug. 2010).

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Economic imperatives to reduce health spending³³³ should ultimately lead to the delivery of more comprehensive care for persons with mental health and substance use disorders even if the Parity Act did not mandate it. With the alignment of good science and good economics, behavioral health care will blend more seamlessly into health care.

³³³ See Ezekiel J. Emanuel, *Spending More Doesn't Make Us Healthier*, N.Y. TIMES OPINIONATOR (Oct. 27, 2011, 12:53 PM), opinionator.blogs.nytimes.com/2011/10/27/spending-more-doesnt-make-us-healthier/.