WHY WON'T PRIVATE HEALTH INSURANCE PAY ITS SHARE OF THE OPIOID CRISIS?

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[W]e enter the ninth year of the insurance company's failure to provide coverage . . . United refus[ed] to give Janie's benefits claim a fair review not once, not twice, but three times—in spite of clear instructions from the district court.[1]

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1. Butler v. United Healthcare of Tenn., Inc., 764 F.3d 563, 568 (6th Cir. 2014).

ABSTRACT

As the novel coronavirus challenges the world, another epidemic tightens its grip: opioids continue to kill more than one hundred Americans each day. The coronavirus epidemic has only intensified the opioid crisis, with spiking overdoses and deaths. Most people with opioid use disorder receive no treatment, but those with private health insurance are treated least of all. The 2008 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Parity Law") requires health insurance companies to treat coverage for mental health, including substance use disorder, the same as coverage for medical and surgical conditions. But since the Parity Law's enactment, insurance companies are paying less overall for consumers' mental health and giving less access to treatment, not more.

This article shows that the Parity Law is an insufficient framework for equality. Skimpy provider networks, delay tactics, opaque definitions, and unequal claims processing still restrict access and cause non-payment of mental health claims, particularly for substance use disorder. The article then shows that current penalties are no match for the financial incentive to underpay. Finally, the article shows that the Parity Law needs

reform, including new penalties and enforcement, just as other landmark laws have needed buttressing. When a polluted Ohio river burst into flame, Congress passed tougher environmental penalties; rampant insider trading prompted new penalties for violating the securities laws. The Parity Law too is at a tipping point, as Americans struggle to secure treatment. The Parity Law needs robust consumer assistance, a common "medical necessity" standard, improved access to external review, new avenues for agency enforcement, and penalties that incentivize fulfillment of the mental health parity promise.

INTRODUCTION

Even as the United States faces a pandemic, the opioid crisis is worsening.[2] As those with opioid use disorder seek treatment, state and federal governments are expanding to meet the need. One significant segment of the healthcare funding system, however, pays less than it should: private, particularly employer-sponsored, health benefit plans.[3]

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Parity Law") prohibits health insurers from discriminating against coverage and claims for mental health, including claims for substance use disorder. But since the Parity Law's enactment, insurance companies are paying less overall for consumers' mental health and providing less access. People with opioid use disorder are less likely to access treatment if they have private health insurance than if they have no health insurance at all. Mental health claims are denied at a much higher rate than those for medical and surgical care. By almost every measure, the inequalities have worsened in recent years.

How is private health insurance able to underpay and reduce access, when the Parity Law demands the opposite? The Parity Law prohibits health insurers from restricting coverage for mental health unless medical and surgical coverage is similarly restricted; terms must be applied equally. The laws do not, however, provide a new private cause of action or penalties for failure to comply. The Parity Law does not change existing laws and regulations governing claims processing and payment;

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2. *See* William Wan & Heather Long, '*Cries for Help': Drug Overdoses Are Soaring During the Coronavirus Pandemic*, WASH. POST (July 1, 2020), https://www.washingtonpost.com/health/2020/07/01/coronavirus-drug-overdose/ ("Nationwide, federal and local officials are reporting alarming spikes in drug overdoses—a hidden epidemic within the coronavirus pandemic."); *see also* Brianna Ehley, *Pandemic Unleashes a Spike in Overdose Deaths*, POLITICO (July 2, 2020), https://www.politico.com/news/2020/06/29/pandemic-unleashes-a-spike-in-overdose-deaths-345183 (noting an "11.4 percent year-over-year" increase in overdose deaths in the early months of 2020).

3. *See infra* section I.A. (explaining those with private health insurance are least likely to receive treatment for substance abuse; even the uninsured are more likely to be treated).

these laws and regulations give private health insurance companies latitude in payment practices and coverage decisions, latitude that is problematic for mental health claims. The Parity Law does little to penalize plan administrators for including prohibited terms in plans or for failing to pay valid claims. Murky plan terms such as "medical necessity" serve as an unpredictable filter. When enforcement means no more than the insurance company paying the claim it should have paid in the first place, insurers have every incentive to delay payment and hope the consumer abandons the claim.

Most consumers with a denied claim do not fight the denial. The alternative is to face a complex and time-consuming appeal process and a potential claim in federal court. For those who cannot pay the up-front cost of treatment, a denial means no treatment at all. A lack of enforcement or penalty means private insurers suffer no consequence when discouraged consumers give up on reimbursement—in fact, private insurers gain from this strategy, and those companies that follow the Parity Law suffer competitively.

To be effective, the Parity Law needs reform, including a uniform medical necessity term, more vigorous enforcement, and penalties for non-compliance. The enforcement burden should fall on health insurance companies and regulators—consumers should not have to take on a complex system to fight for payment.

I. THE MENTAL HEALTH ACCESS & UNDERPAYMENT PROBLEM

Private health insurance is not meeting its obligation to treat mental health claims equally under the Parity Law. This is particularly true with regard to the opioid crisis. As compared to people with medical/surgical claims, those with mental health claims face low provider payments, aggressive utilization review, and thin provider networks.

A. Lack of Treatment

People with private health insurance are often considered fortunate, and for good reason. Health insurance is linked to better access to care across a range of preventive and other care.[4] Health insurance is linked to better disease outcomes and longer life.[5] With treatment for opioid use disorder and mental health treatment in general, however, treatment remains elusive, and these connections are less clear.

4. *See* INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 46 (Nat'l Academies Press 2002).

5. *See id.* at 91.

Most people with opioid use disorder do not receive any treatment at all, regardless of their health insurance status.[6] But people with private health insurance fare worst in this regard—only twenty-one percent of the privately-insured with opioid use disorder received treatment.[7] This rate is much lower than for those with Medicaid, of whom about thirty-eight percent received care.[8] In one study, Medicaid recipients were nearly twice as likely to receive inpatient care as those with private insurance and about three times as likely to have outpatient care.[9] Perhaps most surprisingly, the privately-insured received treatment at even lower rates than the uninsured.[10] Since the Parity Law's enactment in 2009, the percentage of people receiving treatment for substance use disorder has barely increased, despite the ongoing opioid epidemic.[11]

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6. *See* Kendal Orgera & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, KAISER FAMILY FOUND. (May 24, 2019), https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/. In 2017, only thirty-four percent of adults with opioid use disorder received treatment for the condition. *Id.* Of the nonelderly adults who received treatment for opioid use disorder in the previous year, forty-four percent were covered under Medicaid, thirty-two percent were uninsured, and twenty-four percent had private health insurance. *Id.*

7. *See* Chris Lee, *Nonelderly Adults with Opioid Addiction Covered by Medicaid Were Twice as Likely as those with Private Insurance or the Uninsured to Have Received Treatment in 2016*, KAISER FAMILY FOUND. (Apr. 12, 2018), https://www.kff.org/medicaid/press-release/nonelderly-adults-with-opioid-addiction-covered-by-medicaid-were-twice-as-likely-as-those-with-private-insurance-or-the-uninsured-to-have-received-treatment-in-2016/ (demonstrating about forty percent of those with opioid use disorder have Medicaid); *see also* STODDARD DAVENPORT & KATIE MATTHEWS, MILLIMAN, OPIOID USE DISORDER IN THE UNITED STATES: DIAGNOSED PREVALENCE BY PAYER, AGE, SEX, AND STATE 2 (2018). Of the approximately 42 million with private insurance, an estimated 1.5 million were diagnosed with opioid use disorder. *Id.* The number of diagnosed people does not include those who self-report misusing opioids or who might be addicted without being formally diagnosed. *Id.*

8. *See* Orgera et al., *supra* note 6. Medicaid covers about thirty-eight percent of the 1.5 million non-elderly people recently diagnosed with opioid use disorder. *Id.* Nearly half of the adults with opioid use disorder had incomes below 200% of the federal poverty level and Medicaid covers 38% of those with opioid use disorder. *See id.* In addition, many states have applied for section 1115 waivers, so Medicaid can provide additional support for those with opioid use disorder, such as supportive housing, job coaching, and recovery coaching. *See id.* All Medicaid expansion plans must include substance use disorder services as well as mental health and other behavioral health services. *See id.*

9. *See* Valarie K. Blake, *Seeking Insurance Parity During the Opioid Epidemic*, 19 UTAH L. REV. 811, 817–18 (2019); *see also* Emma Peterson & Susan Busch, *Achieving Mental Health and Substance Use Disorder Treatment Parity: A Quarter Century of Policy Making and Research*, 39 ANN. REV. PUB. HEALTH 421, 422 (2018).

10. *See* Orgera et al., *supra* note 6, at fig. 5.

11. *See* Tami L. Mark et al., *Insurance Financing Increased for Mental Health Conditions But Not For Substance Use Disorders, 1984–2014*, 35 HEALTH AFF. 958, 964, exhibit 4 (2016); *see also* Michael Greenwood, *Parity Law has Little Effect on Spending for Substance Abuse Treatment*, YALE NEWS (Jan. 23, 2014), https://news.yale.edu/2014/01/23/parity-law-has-little-effect-spending-substance-abuse-treatment.

Considering the broader landscape of mental health treatment, the gap has recently widened between mental health parity and the actual availability of mental health and substance abuse treatment.[12] By many measures, such as access to in-network care, provider payments, and access to mental health, substance use disorder treatment has worsened in recent years.[13] The authors of a recent, broad mental health parity study describe disparities as "common and generally increasing."[14] This study and many other data points suggest that despite the Parity Law, consumers struggle to access affordable mental health and substance use disorder treatment through their private health insurance plans.[15]

B. Less Overall Spending

Despite the opioid crisis, private health insurers' spending on substance use disorder treatment has not increased significantly in proportion to other categories of healthcare spending. From 2013 to 2017, private health insurers' spending on substance use disorder treatment as a proportion of total healthcare costs ranged from 0.7% of total healthcare spending in 2013, up to 1.0% in 2015 and then lowering in 2017 to 0.9%, despite the opioid crisis during those later years.[16] Private health insurance's share of the total spending on substance use disorders fell from thirty-two percent in 1986 to eighteen percent in 2014, despite the Parity Law and the opioid epidemic.[17] This is not to say that the opioid crisis has not imposed considerable costs on private health insurers—it has.[18] And the opioid crisis has increased the cost of private health

12. *See* STEVE MELEK, STODDARD DAVENPORT & T.J. GRAY, MILLIMAN, ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: WIDENING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT 7 (2019).

13. *See id.* at 6–7.

14. *Id.* at 22.

15. *See id.*

16. *See id.* at 17.

17. *See* Mark et al., *supra* note 11, at 961, exhibit 2; *see also* CHRIS CHRISTIE ET AL., THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS 71 (2017) [hereinafter PRESIDENT'S COMM'N] ("As of 2014, private cost-sharing did not increase in proportion to the private sector share of the insurance market. It financed only 18% of SUD treatment in 2014").

18. Cynthia Cox, Matthew Rae & Bradley Sawyer, *A Look at How the Opioid Crisis Has Affected People with Employer Coverage*, PETERSON-KAISER FAMILY FOUND. HEALTH SYS. TRACKER (Apr. 5, 2018), https://www.healthsystemtracker.org/brief/a-look-at-how-the-opioid-crisis-has-affected-people-with-employer-coverage/.

> In 2016, people with large employer coverage received $2.6 billion in services for treatment of opioid addiction and overdose, up from $0.3 billion in 2004. Of the $2.6 billion spent on treatment for opioid addiction and overdose in 2016 for people with large employer coverage, $1.3 billion was for outpatient treatment, $911 million was for inpatient care, and $435 million was for prescription drugs. In 2016, $2.3 billion in addiction and overdose services was covered by insurance and $335 million was

insurance.[19] Yet private health insurers' spending has not increased at the rate that might be expected, given the doubling of privately-insured people with opioid use disorder in recent years.[20]

C. Higher Denial Rates for Mental Health Claims

Denial rates for mental health claims remain higher than for medical/surgical claims. In one study, patients seeking mental health services from private insurance reported coverage denials at twice the rate of denials for medical services.[21] State investigations have found denial rates for mental health claims ranging from ten percent to thirty percent higher than for medical/surgical claims.[22] The denial rate for more intensive levels of mental health treatment is even higher.[23]

> paid out-of-pocket by patients . . . In 2016, treatment for opioid addiction and overdose represented about 1% of total inpatient spending by people with large employer coverage and about 0.5% of total outpatient spending. In 2004, treatment for opioid addiction and overdose represented about 0.3% of total inpatient spending and less than 0.1% of total outpatient spending.

Id.

19. *See id.* ("On average, inpatient and outpatient treatment for opioid addiction and overdose added about $26 per person to the annual cost of health benefits coverage for large employers in 2016, up from about $3 in 2004.").

20. Karen Shen, Eric Barrette & Leemore S. Duffy, *Treatment of Opioid Use Disorder Among Commercially Insured U.S. Adults, 2008-17,* 39 HEALTH AFF. 993, 996 (2020) (noting that the rate of opioid use disorder increased from 1.7 in 2008 per 1,000 to 3.9 per 1,000 in 2017 among the privately insured).

21. RON HONBERG ET AL., NAT'L ALL. ON MENTAL ILLNESS, A LONG ROAD AHEAD: ACHIEVING TRUE PARITY IN MENTAL HEALTH AND SUBSTANCE USE CARE 4 (2015).

22. The Connecticut Insurance Department reported that in 2015 Connecticut insurance plans' denial rate for mental health claims was one-third higher than for medical care. CONN. INS. DEP'T, CONSUMER REP. CARD ON HEALTH INS. CARRIERS IN CONN. 49–52 (2016). KENNEDY F., ILLINOIS PROVIDERS REPORT BARRIERS TO MENTAL HEALTH & ADDICTION COVERAGE FOR THEIR PATIENTS 5, figure 3 (2017) [hereinafter ILLINOIS REPORT]. A survey of Illinois mental health and addiction care providers revealed numerous barriers to coverage of care: fourteen percent reported that requested acute behavioral treatment services were either "often" or "always" denied, with another forty-one percent reporting that such coverage was "sometimes" denied. *Id.*; *see also*, N.Y. ST. OFF. OF THE ATT'Y GEN. HEALTH CARE BUREAU, MENTAL HEALTH PARITY: ENFORCEMENT BY THE N.Y. ST. OFF. OF THE ATT'Y GEN. 3 n.7 (2018) [hereinafter HEALTH CARE BUREAU] (noting complaints about insurance coverage of mental health/substance abuse treatment grew from 60 substantive complaints in 2011 to nearly 100 in 2012). The New York Attorney General undertook a broad investigation into health plans' compliance with both the federal and state parity laws. *See id.* at 1. The investigation, initiated in 2013, was prompted by an increasing number of citizen complaints about their mental health coverage. *See id.*

23. *See* HEALTH CARE BUREAU, *supra* note 22, at 3 n.7. The New York State Attorney General's investigation of mental health parity law complaints found that one claims administrator denied 36% of Emblem members' requests for inpatient substance abuse rehabilitation coverage and 41% of claims for such care when already received, versus a 20% denial rate for inpatient medical/surgical treatment and 29% denial rate for claims for the same care when already received. *Id.* at 6.

D. Limited Access to In-Network Providers

Health insurance coverage means little if in-network providers are unavailable; consumers generally pay more for out-of-network care.[24] Consumers with private health insurance accessed out-of-network care for all mental healthcare at higher rates than they did for medical/surgical care in recent years.[25]

The disparity is increasing: in 2013, people with private health insurance accessed out-of-network care for all mental healthcare at a rate 2.8 times more than for medical/surgical care.[26] That rate increased to 5.2 times in 2017.[27] As with other data points, substance use disorder patients' access fares worse: the out-of-network treatment disparity is starkest for substance abuse disorder treatment, with consumers seeking inpatient out-of-network care at rates of seventeen percent and the gaps increasing in recent years.[28] For pediatric mental health and substance abuse disorder treatment, access to in-network care was particularly scarce.[29]

The Parity Law does not guarantee any particular level of coverage—it focuses more on processes that are meant to ensure equivalent treatment for mental healthcare. Disparate results in networks, reimbursements, and other measures can, however, suggest compliance problems.[30] As explained below, the Parity Law is intended to lead to equivalent treatment for mental health claims, but key portions of it lack specificity, and the enforcement mechanisms are insufficient. The sections after that describe how health insurance companies can work around the current Parity Law's provisions and deny claims; the final section sets out reforms, enhanced enforcement, and penalties that would help secure parity for mental health and particularly substance use disorder treatment.

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24. Kelly A. Kyanko et al., *Out-of-Network Provider Use More Likely in Mental Health than General Health Care Among Privately Insured*, 51 MED. CARE 8, 699, 700 (2013) (noting that in-network care is generally offered at a lower, negotiated rate while out-of-network care generally costs the consumer more).

25. *See* MELEK ET AL., *supra* note 12, at 6.

26. *See id.*

27. *See id.*

28. *See id.* The proportion of inpatient services provided out of network for mental health/substance use disorder care was at 17.2% in 2017, up from 9.6% in 2013. *See id.* at 10. The same held true for office visits and treatment in outpatient facilities: those seeking mental health or substance use disorder treatment were much more likely to have out-of-network care, ranging from three times more likely in 2014 to four to five times more likely in 2017. *See* MELEK ET AL., *supra* note 12, at 9–10, figure 1.

29. *Id.* at 19 (noting children experience twice the disparity measured for adults). In 2017, a child's visit to a behavioral healthcare provider was 10.1 times more likely to be to an out-of-network provider as to an in-network provider. *Id.*

30. *Id.* at 7.

II. THE MENTAL HEALTH PARITY LAW: A FRAMEWORK FOR PARITY

Congress enacted the first mental health parity law in 1996[31] and has since acted several times to strengthen and expand the provisions. Yet mental health insurance coverage remains marked by inequality and a struggle to obtain care. This disconnect exists because of gaps in the Parity Law and insufficient penalties and enforcement. That is, while the most recent Parity Law contains several provisions requiring equal treatment of mental health claims as compared with medical/surgical claims, the law permits inequalities through murky "medical necessity" provisions, its penalties are slight, and enforcement efforts are understaffed.

The Mental Health Parity Act of 1996 was meant to ease access to mental health treatment by explicitly putting mental health conditions on par with medical and surgical conditions.[32] Following the Mental Health Parity Act's expiration in 2007, Congress again recognized the longstanding discrimination against those seeking help for mental illness[33] and passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008[34] to address this pattern of inequity.[35] The Parity Act does not require employers to offer mental health and substance abuse benefits, but if an employer does, the plan is subject to the Parity Act.[36] In addition, the Parity Act extended mental health coverage to substance use disorder treatment.[37] The Parity Act addresses inequality in mental health by removing certain limitations on

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31. Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addictions Equity Act End the Discrimination?*, 43 GOLDEN GATE U.L. REV. 179, 189–90 (2013). The 1990 Americans with Disabilities Act contained a non-discrimination provision addressing insurance, but it permitted plans to offer less extensive coverage for mental health conditions than for medical/surgical conditions. *Id.*

32. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874, 2944–51 (1996); Michael C. Barnes & Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 565 (2014).

33. *See, e.g.*, Weber, *supra* note 31, at 181 ("Inequality has long been the defining characteristic in health insurance coverage for addiction and mental health treatment."); Blake, *supra* note 9, at 812; Peterson & Busch, *supra* note 9, at 422.

34. *See* Pub. L. 104-204, 110 Stat. 2944 (1996) (codified at 29 U.S.C. § 1185a(3)(A)(ii)).

35. *See Am. Psychiatric Ass'n v. Anthem Health Plans*, 50 F. Supp. 3d 157, 160 (D. Conn. 2014) ("The Parity Act was 'designed to end discrimination in the provision of coverage for mental health and substance use disorders as compared to medical and surgical conditions in employer-sponsored group health plans and health insurance coverage offered in connection with group health plans.'") (quoting *Coal. for Parity, Inc. v. Sebelius*, 709 F. Supp. 2d 10, 13 (D.D.C. 2010)).

36. *See* 29 U.S.C. § 1185a(b)(1) (2021).

37. *See* 29 U.S.C. § 1185a(a)(1).

treatment and ensuring that limitations are applied equally to medical/surgical and mental health treatments.

While the Parity Act applies only to large employer health plans,[38] the Affordable Care Act extends the Party Act's reach to cover plans sold on the ACA's exchanges,[39] and regulations extend the Parity Act's provisions to small group market health plans.[40] States also have mental health parity laws, which they are free to enact as long as the laws are no less generous than the federal law.[41]

The Parity Law contains the following explicit prohibitions against unequal treatment for mental health coverage and enforcement provisions.

A. Equal Application of Coverage Limitations

Coverage for certain mental health treatment used to be subject to explicit limits, known as quantitative limits, such as a course of twenty-eight days of substance use disorder rehabilitation. The same type of limits generally did not apply to medical/surgical claims. The Parity Law prohibits this explicit disparate treatment.[42] The prohibition applies to both quantitative and non-quantitative treatment limitations.[43]

1. No Disparity in Quantitative Treatment Limitations

Quantitative treatment limitations include limitations that can be measured numerically, such as days or number of visits.[44] A mental health benefit cannot be limited in such a way unless a medical or surgical benefit is similarly limited.[45] Lifetime limits for mental health and substance use disorder benefits are also prohibited unless applied equally to medical/surgical benefits.[46]

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38. *See* 29 U.S.C. § 1185a(c)(1).

39. 42 U.S.C. § 18031(j) (2021) ("[The Parity Law] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.").

40. *See* Patient Protection and Affordable Care Act, 78 Fed. Reg. 12834, 12844 (Feb. 25, 2013) (to be codified at 45 C.F.R. 156) (expanding access to mental health and substance use disorder treatment by requiring some coverage of these disorders in small group plans, individual plans, plans sold on the insurance exchanges, and Medicaid plans).

41. *See* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68252 (Nov. 13, 2013) (to be codified at 45 C.F.R. 146) [hereinafter Final Rules].

42. *See* 29 U.S.C. § 1185a(a)(3)(A)(i).

43. *See* 29 U.S.C. § 1185a(a)(2)(B).

44. *See* 29 U.S.C. § 1185a(a)(3)(B)(iii).

45. *See* 29 U.S.C. § 1185a(a)(2)(A).

46. *See* 29 U.S.C. § 1185a(a)(1)(A).

2. No Disparity in Non-Quantitative Treatment Limitations

Non-quantitative treatment limitations (NQTLs) are not numerically quantifiable but can still limit treatment. These include matters of plan design, reimbursement, application of the medical necessity criteria, and many others.[47] Any NQTL imposed on mental health treatment must be applied equally to medical/surgical claims.[48] The test for applying NQTLs equally across medical/surgical and mental health claims remains murky—the term is meant to be applied "comparabl[y] . . . and . . . no more stringently" to mental health claims than they are to medical/surgical claims.[49]

The parity requirement for NQTLs also applies to plans' "medical necessity" term—this kind of term significantly affects consumer access to treatment and coverage.[50] Practically all health insurance plans contain a multi-part, complex "medical necessity" limitation; because of their multiple parts, these can be vague and difficult to pin down.[51]

3. Parity in Provider Access to Networks

Provider access to networks is also considered an NQTL. For example, if a plan populates its network of medical/surgical providers by ensuring that a consumer can obtain an appointment within fifteen days of requesting one, then the plan must use the same standard when populating its mental health and substance abuse plan.[52]

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47. *See* 29 C.F.R. § 2590.712(c)(4)(i) (2021). NQTLs can include medical necessity terms, experimental or investigative exclusions, formulary design for prescription drugs, network tier design (such as preferred and participating providers), standards for providers' participation in networks, provider reimbursement rates, methods for determining usual and customary charges, "fail-first" or step protocols (protocols by which a person must first fail at one treatment before a more intensive or costly therapy is authorized), exclusions based on failure to complete a course of treatment, restrictions based on geographic location, facility type, or other criteria that limit the benefits, prior notice requirements, service coding, limits on inpatient services where a person is a threat to self or others. *Id.*

48. *See* 29 C.F.R. § 2590.712(c)(4) ("[A]ny processes, strategies, evidentiary standards, or other factors used in applying [the standard must be] comparable to, and applied no more stringently than, [those imposed] with respect to medical/surgical benefits."); 29 C.F.R. § 2590.712(c)(2)(i). Limitations applied to mental health treatments must be equivalent to a limitation applied to the analogue category of facility or treatment for medical/surgical treatment; Final Rules, *supra* note 41, at 68241 (In addition, the final regulation eliminated an exception that had allowed for different NQTLs "to the extent that recognized clinically appropriate standards of care may permit a difference.").

49. 29 C.F.R. § 2590.712(c)(4)(i).

50. Weber, *supra* note 31, at 218.

51. Barnes, *supra* note 32, at 580 (noting that a medical necessity term was once used to categorically deny coverage for autism spectrum disorders without even considering whether the treatment was in fact medically necessary).

52. *See* U.S. DEP'T OF LAB. ET AL., FAQS ABOUT MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39 10 (Sept. 5,

4. Parity in "Fail-First" Protocols

"Fail-first" or step protocols (those that require a participant to fail at a less intensive therapy before accessing a more intensive one) are also forbidden unless applied equally to medical/surgical claims. Such protocols have long served as the basis for denials of mental health claims, particularly for expensive inpatient treatment.[53] Fail-first protocols are also prohibited if the first step cannot reasonably be satisfied, such as without a provider's availability.[54]

A violation results from the use of incorrect or unfair standards, rather than from variations in the number of visits or days between mental health and medical treatment.[55]

5. Equivalent Facilities for Mental & Medical/Surgical Care

The Parity Law also requires that plans cover equivalent types of facilities for both mental and medical claims. For example, if a plan covers skilled nursing facilities for medical claims, then the Parity Law requires that it cover the equivalent facility—residential treatment centers for mental health treatment.[56] Plans have based denials on the exclusion of such residential treatment centers for mental health treatment, but courts addressing the matter under the Final Rules and even before have held that the facilities are equivalent to covered facilities for medical claims and so must likewise be covered.[57] While many plans already

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2019) [hereinafter FAQS PART 39], https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf. The failure to apply the same standards to building both medical/surgical and mental health/substance use disorder networks is a violation of the parity laws. *Id.*

53. *See id.* at 8. The Departments have insisted in guidance, however, that such protocols violate the Parity Act unless they are imposed in the same way on mental health and medical and surgical claims alike. *See id.* These protocols violate the Parity Act if they require two steps for mental health claims and just one for medical claims. *See id.* The Departments noted that unless such different standards were developed using comparable evidentiary standards, the use of such different standards would probably violate the Parity Act. *See* FAQS PART 39, *supra* note 52, at 8.

54. *See* U.S. DEP'T OF LAB. ET AL., FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 34 AND MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION 11 (Oct. 27, 2016) [hereinafter FAQS PART 34], https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf.

55. *See* 29 C.F.R. § 2590.712(c)(4)(ii) (2021). If "evidentiary standards are applied in a manner based on clinically appropriate standards of care for a condition," the plan complies with the Parity Act even if the application of the evidentiary standards results in a different number of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for a particular medical/surgical condition. *See id.*

56. *See* 29 C.F.R. § 2590.712(c)(4)(ii).

57. *See* B.D. v. Blue Cross Blue Shield of Ga., No. 1:16-cv-00099-DN, 2018 U.S. Dist. LEXIS 16993, at *8–9 (N.D. Utah Jan. 31, 2018); *see also* Natalie V. v. Health Care Serv.

viewed inpatient mental health facilities in this way,[58] others denied claims on this basis, leading to protracted litigation to obtain the coverage.

B. Disclosure

The Parity Law requires that plans disclose important information about mental health and substance use disorder benefits to consumers. This includes the reason for any denial of benefits and the instruments under which the plan operates.[59] Documents that contain the procedures, formulas, methodologies, schedules, or documents used in determining or calculating a benefit are considered instruments under which the plan is established or operated.[60]

Plans must disclose their medical necessity criteria upon request from a beneficiary, contracting provider, participant, or potential participant on request.[61] Plans sometimes resist disclosing this information, claiming that it is protected by commercial interests or that it has proprietary value; sometimes, they just do not disclose it.[62] Information such as this must be disclosed to participants within thirty days. The failure to disclose documents under the Employee Retirement

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Corp., No. 15-C-09174, 2016 U.S. Dist. LEXIS 123783, at *15 (N.D. Ill. Sep. 13, 2016) (first citing 29 C.F.R. § 2590.712(c)(2)(i) (2021); and then citing Final Rules, *supra* note 41, at 68244)) (requiring coverage under the Parity Law for residential mental health treatment, even before the Final Rules made clearer that such facilities should be covered).

58. In an investigation before the Final Rules were issued, the Departments investigated their impact and decided that there would be few additional costs attributable to the Final Rules. *See* Final Rules, *supra* note 41, at 68260. This was because most plans were already categorizing residential mental health facilities as equivalent to skilled nursing facilities and were covering mental health treatment in such facilities on that basis. *See id.*

59. *See* 29 C.F.R. § 2590.712(d)(2).

60. *See id.*

61. *See* 29 C.F.R. § 2590.712(d)(3).

62. For example, in an October 2015 guidance, the Departments addressed a plan's refusal to disclose its medical necessity criteria, arguing that that the information was proprietary or had commercial value. U.S. DEP'T OF LAB. ET AL., FAQ ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XXIX) AND MENTAL HEALTH PARITY IMPLEMENTATION 9 (Oct. 23, 2015), https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxix.pdf. The plan had used the criteria to deny a claim for inpatient treatment for anorexia nervosa, a mental health benefit under the plan. *See id.* at 10. The guidance stated that the plan had to disclose the information under the Parity Law and ERISA. *See id*. at 10–11. The Departments deemed the medical necessity criteria "instruments under which the plan was established or is operated" for the purposes of the ERISA disclosure requirement, contained in 29 U.S.C. § 1024(b)(2) (citing U.S. DEP'T OF LABOR EMP. BENEFITS SECURITY ADMIN., Advisory Opinion 1996-14A (July 31, 1996)). *Id.* at 11. Thus, even if the information is held by a third-party commercial vendor, the information must still be disclosed. *Id.*

Income Security Act (ERISA) can lead to penalties of up to $110 per day from the date of the failure to disclose the documents.[63]

The Department of Labor (DOL) claims regulations contain further disclosure requirements, requiring that a participant appealing a final claim denial be provided, on request and free of charge, access to and copies of all documents, records, and other information relevant to a benefits claim.[64]

C. Enforcement

The states have primary authority to enforce the parity laws with regard to health insurance issuers that are licensed by the states and that state law governs.[65] Centers for Medicare and Medicaid Services (CMS) has secondary enforcement authority over issuers in the individual and group markets, which comes into play if the state "notifies CMS that it has not enacted legislation to enforce or is otherwise not enforcing [the parity laws], or if CMS determines that the State is not substantially enforcing [the ACA or parity law]."[66] The DOL and Health and Human Services have enforcement authority over private-sector employer-sponsored plans subject to ERISA.[67]

Consumers, regulators, and state attorney generals are able to enforce aspects of the Parity Law.

1. Consumer Enforcement

Consumers seeking to enforce their rights under the Parity Law can do so through plan appeals and then though litigation in federal court.

A. Internal & External Appeals

Health insurance plans are required to have an internal appeal process through which a denied claim can receive a "full and fair review"

63. FAQS PART 39, *supra* note 52, at 21. The Departments have disseminated a model disclosure form that consumers can use to request documentation from plans regarding treatment limitations that may affect access to mental health or substance use disorder benefits. *Id.* at 19–21.

64. *See* 29 C.F.R. §§ 2560.503-1, 2590.715-2719, 2590.712(d)(3) (2021). New information or rationales for denial must be provided as soon as possible, sufficiently in advance of when the denial notice is required so the participant can respond. *See* 29 C.F.R § 2590.712(d)(2).

65. *See* 42 U.S.C. §§ 300gg(a)(2)(A), 1136(a) (2021); *see also* Final Rules, *supra* note 41, at 68252 (section 2723(a) of the PHSA gives the states "primary enforcement authority over health insurance issuers."); 26 U.S.C. § 9832(b)(2) (2021) (A "health insurance issuer" is "an insurance company, insurance service, or insurance organization . . . licensed to engage in the business of insurance in a State and which is subject to State law").

66. Final Rules, *supra* note 41, at 68252; 29 U.S.C. § 1136(b)–(c).

67. *See* 29 U.S.C. § 1003(a)–(b) (2021).

of the denial.[68] For group health plans, any denial must list the reason for the denial, a description of information needed to perfect the claim, a description of the plan's review procedures and time limits, and a statement of the consumer's right to sue under ERISA following a denial on review.[69] On appeal, a consumer is entitled to a review that does not defer to the original decision that is performed by an impartial fiduciary, that is done with proper medical judgment and training if a medical judgment is required, that considers all submitted information, and that fulfills all the additional regulatory requirements.[70]

The ACA made the availability of external review mandatory—an external review is meant to provide an independent analysis of a claim so that the correct decision can be reached. Under the ACA's rules, group health plans and insurers in the group and individual market can comply with either a state or federal external review process.[71] Plans must "implement an effective external review process that meets minimum standards established by the Secretary."[72] Under the external review rules, plans must assign external reviews to an independent review organization accredited by the Utilization Review Accreditation Commission or by another national accrediting organization.[73] On external review, claims are to be reviewed de novo, without deference to the previous denial.[74]

B. Lawsuit in Federal Court

The Parity Law provides no new private cause of action;[75] the law is incorporated into ERISA, and an ERISA plan beneficiary can sue to enforce the Parity Law through ERISA's civil enforcement provision.[76]

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68. *Id.*

69. *See* 29 U.S.C. § 1132(a) (2021).

70. *See* 29 C.F.R. § 2560.503-1(h), (m) (2021).

71. *See* 29 C.F.R. § 2590.715-2719(c) (2021).

72. 29 C.F.R. § 2590.715-2719(b)(1).

73. *See* U.S. DEP'T. OF LABOR, TECHNICAL RELEASE NO. 2010-1, INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010).

74. *See id.*

75. L.P. v. BCBSM, Inc., No. 18-cv-1241, 2020 U.S. Dist. LEXIS 35239, at *16 (D. Minn. Jan. 17, 2020).

76. 29 U.S.C. § 1132(a)(1)(B) (2021). ERISA contains an enforcement provision stating that "[a] civil action may be brought . . . by a participant or beneficiary . . . 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." N.Y. State Psychiatric Ass'n, Inc. v. United Health Grp., 980 F. Supp. 2d 527, 541–43 (S.D.N.Y. 2013), *aff'd in part, vacated in part*, 798 F.3d 125, 133 (2d Cir. 2015). As part of the federal lawsuit, a mental health parity plaintiff may assert either a "categorical" violation or an "as-applied" violation; a categorical violation is one that challenges a limitation in the plan, while an as-applied violation challenges the disparate application of an otherwise-permissible limitation. *L.P.*,

ERISA allows a plaintiff to bring a case to "recover benefits due . . . under the terms of the . . . plan, to enforce[] rights under the terms of the plan or to clarify [their] rights to future benefits under the terms of the plan."[77]

To seek review of the claim in federal court, consumers must overcome two important limitations. First, before suing in federal court, a plaintiff must first exhaust the levels of appeal available within the plan.[78] Consumers cannot recover attorneys' fees for that phase of the process, and consumers without help may be overwhelmed by the appeal process, particularly as they are likely coping with underlying illness at the same time.[79] Second, a plan's denial of a claim is generally reviewed under the arbitrary and capricious standard of review, meaning that a plan's claim denial remains in place unless the decision was made without a basis in evidence in the record.[80]

When a plaintiff shows that the claim denial was unreasonable, the result is most often a remand for further consideration rather than payment in full and attorneys' fees.

2. Federal Agency Enforcement

The DOL, through the Employee Benefits Security Administration (EBSA), enforces Title I of ERISA, including the Parity Law, for 2.4 million private, employer-sponsored group health plans.[81]

The current enforcement approach is, for the most part, a collaborative one, based on informing insurers about the Parity Law and reviewing plans when necessary.[82] EBSA states that it can sue employer-based plans and sue for equitable relief, but it more often works

2020 U.S. Dist. LEXIS 35239, at *16 (citing H.H. v. Aetna Ins. Co., 342 F.Supp.3d 1311, 1319 (S.D. Fla. 2018)).

77. 29 U.S.C. § 1132 (a)(1)(B) (2021).

78. D'Amico v. CBS Corp., 297 F.3d 287, 291 (3d Cir. 2002) (citing Harrow v. Prudential Ins., 279 F.3d 244, 253 (3d Cir. 2000)).

79. *See, e.g.*, KAREN POLLITZ & CYNTHIA COX, HENRY J. KAISER FAMILY FOUND., MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE 29–30 (2014) (explaining that people with health insurance are often overwhelmed by a high volume of medical bills and are also dealing with underlying illnesses, all of which hampers their ability to fight denials).

80. *See* Champion v. Black & Decker (U.S.) Inc., 550 F.3d 353, 358 (4th Cir. 2008) (quoting Metro. Life Ins. Co. v. Glenn, 55 U.S. 105, 111 (2008)). Courts must review a benefit denial de novo, unless a plan grants the administrator discretionary authority to determine eligibility for benefits; if the administrator has discretion and is operating under a conflict of interest, then that conflict is weighed in the review. *See id.*

81. *See* U.S. DEP'T OF LABOR EMP. BENEFITS SEC. ADMIN, FACT SHEET: FY 2019 MPAEA ENFORCEMENT 1 (2019), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2019.pdf.

82. *See* SEC'Y OF HEALTH & HUM. SERV., 21ST CENTURY CURES ACT: SECTION 13002 ACTION PLAN FOR ENHANCED ENFORCEMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE 4 (2018).

"collaboratively" with the issuers.[83] EBSA's plan for enhanced enforcement depends in part on insurers' willingness to comply once they understand the Parity Laws.[84] EBSA refers to its strategy as a "voluntary global correction" approach because, once it finds a violation, it seeks compliance throughout the company's plans.[85] For issuers that *want* to comply with the Parity Law, the resources are available.[86] Based on its own mission and directives from the 21st Century Cures Act, EBSA has provided a host of resources, FAQs, and disclosure guidance.[87]

For issuers that do not comply voluntarily, the federal enforcement effort is less effective. The EBSA has 400 investigators, but their task is enormous: to police 2.4 million employer-sponsored plans covering about 135 million participants and beneficiaries.[88] In 2019, EBSA conducted 186 health plan investigations and cited 12 Parity Law violations in 9 of the investigations.[89]

In response to the opioid crisis, the EBSA has created targeted regional efforts to help ensure that those with opioid-related disorders receive benefits on par with medical benefits.[90] Rare as these compliance reviews are (reviewing only one in 11,764 plans in 2017), even these have not led to fines when a violation is discovered. The EBSA only requires that the plan remove prohibited language and pay the improperly denied claims.[91] Even when EBSA finds a clear Parity Law violation, such as an annual limit on mental health visits for substance use disorder where there

83. *Id.*

84. *See id.* ("EBSA . . . has been able to work collaboratively with issuers to ensure widespread corrections by issuers and third-party administrators for thousands of group health plans. In addition, EBSA has worked closely with state insurance departments to ensure that the law's requirements are understood").

85. EUGENE SCALIA, U.S. DEP'T OF LABOR, PARITY PARTNERSHIPS: WORKING TOGETHER REPORT TO CONG. 7 (2020), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf ("When EBSA identifies violations in a particular group health plan, EBSA asks the plan to make necessary changes to any noncompliant plan provision and to re-adjudicate any improperly denied benefit claims").

86. *See id.* at 20. HHS maintains resources for issuers, such as self-compliance checklists, examples of plan terms that are "red flags" of non-compliance with the Parity Laws, and studies of the Parity Laws' impact. *See id.*

87. *See id.* at 10.

88. *See* U.S. DEP'T OF LABOR, *supra* note 81, at 1.

89. *See id.* at 3.

90. *See* R. ALEXANDER ACOSTA, U.S. DEP'T OF LABOR, PATHWAY TO FULL PARITY, REPORT TO CONG. 14 (2018), https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf.

91. *See* U.S. DEP'T OF LABOR, *supra* note 81, at 2.

was no annual limit for medical/surgical visits, there was no penalty except to reprocess the claims.[92]

In addressing challenges to Parity Law enforcement, the DOL has cited its lack of authority to impose fines for noncompliance, even where bad actors and the most egregious cases of noncompliance are concerned.[93] The report also notes that the agency has just one investigator for every 12,500 benefit plans.[94] Thus, the federal effort provides information for those plans that want to comply and for consumers who can advance their positions. But where issuers are determined to flout the law or impose improper costs on those seeking mental healthcare and substance use disorder treatment, in particular, the chances of detection are slight, and the cost imposed on the issuer upon detection is simply to do what it should have done in the first place.

3. State Attorneys General

State attorneys general can also enforce the Parity Law, including state parity laws. The New York State Office of the Attorney General's Office, for example, has vigorously enforced the state and federal parity laws.[95] After noticing an uptick in consumer complaints to its hotline, New York State's Attorney General investigated eight different companies and found that utilization review was overly aggressive for mental health claims, residential treatment was improperly excluded, and copays were higher for mental healthcare.[96] As a result of the enforcement actions, the plans reimbursed two million dollars for previously-denied claims, paid three million dollars in penalties, and are reportedly easing the path to necessary mental health treatment.[97] In addition, some of the companies reported lower denial rates for mental health treatment after they entered into settlement agreements with the New York Attorney General's Office.[98]

The Massachusetts Attorney General too has investigated multiple insurers, resulting in changes to reimbursement rates, removal of

92. *See id.* at 6 (discussing the EBSA Cincinnati Regional Office's investigation that 500 schools relied upon to sponsor group health plans for their employees).

93. *See* ACOSTA, *supra* note 90, at 6. The Parity Law requires that the Secretary of Labor submit a report to Congress every two years on the group health plans' compliance with the Parity Act. *See id.* at 3.

94. *See id* at 6. Although the 2018 DOL report agreed that the Department could better enforce the law if it had the power to impose penalties, the 2020 report did not include this language or ask for enforcement powers, including penalties. *See* SCALIA, *supra* note 85, at 6–9.

95. *See* HEALTH CARE BUREAU, *supra* note 22, at 6–9.

96. *See id.* at 3.

97. *See id.* at 1.

98. *See id.* at 6.

improper preauthorization requirements, and the addition of providers to networks.[99]

4. The Excise Tax

Under the Internal Revenue Code, certain violations of the Parity Law or the ACA result in an excise tax.[100] For each employee harmed by an employer's Parity Law or ACA violation, the employee must pay $100 per day, with the tax liability continuing throughout the violation period.[101]

The excise tax is self-reported by the employer sponsoring the non-compliant plan and is not brought by the party harmed.[102] In addition, the excise tax contains defenses and exceptions that would result in the imposition of no tax. The tax does not apply if the employer did not know and would not have known after reasonable diligence that it failed to comply with the law; the tax also does not apply if the employer corrected the violation within thirty days of the date it knew or should have known of its failure to comply.[103] In addition, the government may waive the tax if it is due to "reasonable cause and not willful neglect."[104]

Non-compliance is considered corrected if the failure is "retroactively undone" or if the person to whom the failure relates is in the same financial position as if the plan had been compliant.[105] Thus, if a claim is delayed for a long period of time through a number of appeals and a federal lawsuit due to parity non-compliance, the non-compliance could be considered "corrected" if the parity violation is eventually eliminated and the claim paid; arguably, even under this scenario, the excise tax would not be payable as the violation would be corrected.

99. *See* Press Release, Maura Healey, Mass. Att'y Gen., Agreements with Five Health Insurers and Two Behavioral Health Companies are Part of AG Healey's Extensive Behavioral Health Parity Investigation (Feb. 27, 2020), https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services.

100. *See* 26 U.S.C. § 4980D (2021).

101. *See* 26 U.S.C. § 4980D(b)(1)–(2).

102. *See* Joseph J. Lazzarotti & Raymond P. Turner, N*ew Obligation to Self-Report Excise Taxes for Group Health Plan Failures*, JACKSON LEWIS (Jan. 10, 2010), https://www.jacksonlewis.com/resources-publications/new-obligation-self-report-excise-taxes-group-health-plain-failures.

103. *See* 26 U.S.C. § 4980D(c)(2).

104. 26 U.S.C. § 4980D(c)(4).

105. 26 U.S.C. § 4980D(f)(3) ("A failure of a group health plan shall be treated as corrected if . . . the person to whom the failure relates is placed in a financial position which is as good as such person would have been in had such failure not occurred.").

Some practitioners report that even upon audit, the excise tax for health plan non-compliance is rarely imposed.[106]

There is no penalty for mental health parity violations, even if the consumer must self-pay the claims initially and then take years to work through multiple levels of appeal within the plan, sue in federal court, and then prevail under the uphill battle that is the "arbitrary and capricious" standard of review. Achieving mental health parity requires spending money to pay claims. Given the lack of incentives to comply with the law, private health insurers use direct and indirect methods to avoid paying mental health claims and especially substance abuse disorder claims.

III. DODGING THE PARITY LAW: DELAY & DENIAL OF MENTAL HEALTH CLAIMS

Mental health advocates and professionals greeted the Parity Law with high hopes for access to mental healthcare.[107] Yet since the law's passage, mental health access and claims payment have only decreased.[108] Today, prohibited quantitative limits on mental health benefits still occasionally exist,[109] but they are easier to detect and correct than more subtle disparities in the terms' application to individual

106. Joseph J. Lazzarotti & Raymond P. Turner, *New Obligation to Self-Report Excise Taxes for Group Health Plan Failures*, JACKSON LEWIS (Jan. 14, 2010), https://www.jacksonlewis.com/resources-publication/new-obligation-self-report-excise-taxes-group-health-plan-failures.

107. Press Release, Am. Psychological Ass'n, Landmark Victory: Mental Health Parity is Now Law (Oct. 3, 2008) ("President Bush signed mental health parity into law today, taking a great step forward in the decade-plus fight to end insurance discrimination against those seeking treatment for mental health and substance use disorders. This historic legislation requires that health insurance equally cover both mental and physical health").

108. Weber, *supra note* at 31, at 184–85.

109. Despite the clear prohibition on unequal quantitative limits that have existed for years, EBSA still finds plan provisions that contain such limits. Examples of violations found in 2017 include "an impermissible annual day limit on residential treatment for substance use disorders," a higher co-payment for mental health and substance abuse visits as compared with medical visits, a failure to cover out-of-network mental health and substance use disorder benefits, and overly stringent precertification requirements. U.S. DEP'T OF LABOR, *supra* note 81, at 3. Investigations and lawsuits have also uncovered plan terms that impermissibly exclude, for example, treatment for developmental disabilities. *See, e.g.*, A.F. v. Providence Health Plan, 35 F. Supp. 3d 1298, 1315 (D. Or. 2014) (holding that a "developmental disability" exclusion violated state and federal parity laws because it applied only to mental health treatment and not to medical/surgical treatment); Joseph F. v. Sinclair Servs. Co., 158 F. Supp. 3d 1239, 1261–62 (D. Utah 2016) (holding that exclusion of residential treatment for substance use disorder and mental health violated the parity laws, where the plan did not exclude residential treatment for medical and surgical treatment); Munnelly v. Fordham Univ. Faculty & Admin. HMO Ins. Plan, 316 F. Supp. 3d 714, 732–34 (S.D.N.Y. 2018); Danny P. v. Catholic Health Initiatives, 891 F.3d 1157, 1160 (9th Cir.).

claims.[110] A review of the plan documents reveals whether particular benefits are covered, but not the benefits' scope or how utilization standards are applied.[111] Even trained reviewers cannot determine from plan documents whether plans actually comply with the mental health Parity Law—consumers have even less chance of knowing whether parity violations exist.[112]

As plan networks are populated with providers and claims are processed individually, opportunities for disparate treatment abound. Mental health providers report problems joining plan networks (even though provider terms for joining networks are subject to the Parity Law); the networks are often skimpy. Mental health claims face unfairly strict utilization review and delays. Enforcement of the Parity Law is light, depending on consumers to raise issues, approach the proper authorities, and press their claims, even as they battle the mental health issues themselves. These individual disparities are hard to uncover, yet wrongdoers face only correction and payment of the improperly denied claim.

A. The "Medical Necessity" & Internal Guidelines Loophole

Mental health claims are vulnerable to denial under plans' "medical necessity" term and other internal claims processing guidelines. The Parity Law explicitly allows a medical necessity term, often required for any treatment to be a covered service.[113] Claims processing should be

110. ELLEN WEBER ET AL., ADDICTIONS SOLUTIONS CAMPAIGN, PARITY TRACKING PROJECT: MAKING PARITY A REALITY 3 (2017); *see* PRESIDENT'S COMM'N, *supra* note 17, at 71 ("MHPAEA has been the impetus for much progress towards parity for behavioral health coverage; plans and employers have, by and large, done away with policies that are clear violations; provisions such as dollar limits, visit limits, and outright prohibitions on certain treatment modalities that exist only on behavioral health benefits. However, what remains are violations that are murkier and harder for regulators to discern, for example, non-quantitative treatment limits (NQTLs). These hurdles include medical necessity reviews that are more stringent on the behavioral health side than the medical/surgical side, limited provider networks, and onerous prior authorization requirements").

111. WEBER ET AL., *supra* note 110, at 7.

112. *Id.* at 8 (concluding that it is "challenging, if not impossible" for an average consumer to use publicly available plan documents to determine whether a parity violation exists).

113. 45 C.F.R. § 146.136(a), (c)(4)(ii)(A) (2021) (setting out non-quantitative treatment limits that are permitted if applied evenly, including "[m]edical management standards limiting or excluding benefits based on medical necessity or medical appropriateness"). As an example, here is the definition of "medically necessary" from a Blue Cross Blue Shield of Texas employer-sponsored plan in 2018:

> Medically Necessary or Medical Necessity means those services or supplies covered under the Plan which are: 1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and 2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and 3. Not

"consistent with generally recognized independent standards of current medical practice."[114]

In practice, the term and its guidelines act as a significant gatekeeper, central to insurers' cost containment strategies.[115] For medical as well as mental health claims, the medical necessity requirement has long resulted in inconsistent and problematic decision-making.[116] Because of the terms' multi-part definitions and lack of objective measures for satisfying them, their interpretation invites non-objective considerations: "[m]edical necessity determinations depend on the knowledge, politics, motives, and inclinations of those who render them far more than they depend on objective truths."[117] The term can result in denial even when care is clinically indicated.[118] One commentator believes that medical necessity terms are inevitably ambiguous and a poor source of decision-making, as long as health care in the United States is a private and pluralistic system.[119] At present, each state and each plan governed by federal law can create its own medical

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> primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and 4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient. The medical staff of [the Claim Administrator] shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

BLUECROSS BLUESHIELD OF TEXAS, YOUR HEALTH CARE BENEFITS PROGRAM 63–64, https://www.bcbstx.com/static/tx/pdf/policy-forms/mmh3.pdf (last visited Apr. 30, 2021).

114. 29 C.F.R. § 2590.712(a) (2021).

115. Janet L. Dolgin, *Unhealthy Determinations: Controlling "Medical Necessity"*, 22 VA. J. SOC. POL'Y & L. 435, 436 (2015).

116. William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 601 (2003) ("[D]ecisions involving medical necessity are frequently characterized by inconsistent administration, poor communication, distrust and, if disputes arise, relatively unprincipled, results-oriented judicial resolution").

117. Dolgin, *supra* note 115, at 443.

118. *Id.* at 438–39 (quoting Sage, *supra* note 116, at 601) ("[V]arious stakeholders assume different interpretations of the phrase . . . To many health plans, [the term] means 'not covered even though not expressly excluded from coverage,' which gives them a degree of comfort issuing denials based on established insurance practice even though such decisions outrage physicians.'").

119. Sage, *supra* note 116, at 604.

necessity definition and criteria, which can lead to inconsistency across plans and a lack of clarity about what will and will not be covered.[120]

While a plan may promise to cover care in accordance with "generally accepted standards of care," the reality may be far more restrictive for mental health and substance use disorder claims. The *Wit* class action case in California recently served as a window into the differences between the standards plans advertised and reality on the ground.[121]

After a ten-day bench trial, the *Wit* court concluded that the claims administrator in question made substance use disorder coverage decisions for multiple health plans based not on the promised "generally accepted standards of care" but on more restrictive guidelines that it developed internally.[122] The guidelines were not plan terms, they diverged in multiple respects from generally accepted standards of care, and they were more stringent.[123] When the administrator's clinical staff recommended that the company instead adopt the ASAM criteria, "to get in line with evidence based guidelines for our policies around Substance Use," the CEO requested a statement of the "impact" from the financial department; the financial department would not sign off on the change.[124] The court found that despite the administrator's fiduciary duties toward the plan members, the administrator put profits first, "prioritizing cost savings over members' [recovery of benefits]."[125]

Moreover, where certain states mandated the use of their own medical necessity definitions for plans governed by state law, the claims administrator ignored that definition and substituted its own more restrictive definition.[126] In this way, the claims administrator may have violated the laws of Illinois, Connecticut, Rhode Island, and Texas.[127]

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120. United States Psychiatric Rehabilitation Association, Comment Letter on the Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equality Act of 2008 (Public Law 110-343) (May 26, 2009), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/1210-AB30/00250.pdf.

121. The *Wit* class action included claims based on multiple plans against an administrator of those plans; some of the plans were fully insured, and others were funded by employers. Wit v. United Behav. Health, No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205, at *14 (N.D. Cal. Feb. 28, 2019).

122. *Id.* at *38–39.

123. *Id.* at *30 (citing defense expert testimony admitting that the "clear and compelling" standard for continued treatment at a specific level of care was an "impossible metric" and that "any practitioner worth his salt" would not rely on these guidelines, even though they are the operative guidelines for decision-making).

124. *Id.* at *196–97.

125. *Id.* at *23–24.

126. *Wit*, 2019 U.S. Dist. LEXIS 35205, at *84–87.

127. *Id.* at *170.

Overall, the court found that the desire for profits tainted the entire process of developing standards and applying them.[128] And, in applying the guidelines, United Behavioral Health ("UBH") constantly received information about utilization, so it could ensure that its financial targets were being met.[129] The *Wit* class action shows how concern for profitability influences the medical necessity guidelines and taints the claims review process.

B. Mistakes & Delay

Consumers facing improperly delayed or denied claims must work through a multi-stage appeal process and eventually seek redress in federal court if the claim continues to be denied. When consumers persist to this point, the resulting proceedings often reveal multiple mistakes and delays.

An administrator took *seven years* and resisted repeated court orders before it finally paid a claim for alcohol abuse coverage.[130] In the course of the treatment, internal and external appeals, and eventual lawsuit, the administrator made numerous mistakes, such as applying the wrong medical necessity standard in denying the claim, failing to disclose the standard until litigation began, and failing to provide the requisite "full and fair" review.[131]

An administrator denied claims for a child's mental health benefits, did not provide the plan document upon request, and did not even send a denial when requested.[132] Three years after the treatment, the claims were finally paid, but not before the plaintiff had to suffer considerable financial hardship in paying for the treatment herself.[133]

An administrator based denials on reasons that were not stated in the plan and attempted to deny appeals as untimely, citing a 60-day time limit for a second appeal, even though the plan gave 180 days to appeal.[134] Despite this clearly incorrect application of plan terms, the only remedy

128. *Id.* at *186.
129. *Id.* at *188.
130. Butler v. United Healthcare of Tenn., Inc., 764 F.3d 563, 564 (6th Cir. 2014).
131. *Id.* at 566.
132. Easter v. Cayuga Med. Ctr. at Ithaca Prepaid Health Plan, 217 F. Supp. 3d 608, 625–26 (N.D.N.Y. 2016) (noting the "significant procedural deficiencies" that consisted of the issuer failing to respond to the plaintiff's requests, failing to keep copies of correspondence, and lack of notice of appeal).
133. *Id.* at 626 (noting the "significant economic hardship" that the plaintiff suffered, as the defendant failed to respond to her request for a decision on the claim submissions).
134. Aviation W. Charters, LLC v. United Healthcare Ins. Co., No.1: 16-CV-210, 2017 U.S. Dist. LEXIS 102561, at *9, *12–13 (N.D. Ohio June 30, 3017).

was to conduct the appeal that the defendant should have conducted in the first place.[135]

Where a plan excluded residential mental health treatment without an equivalent exclusion for medical treatment, the plan participant had to sue in federal court to obtain the benefits.[136] This is a clear violation of the Parity Law,[137] a decade after parity became the law, and yet the plaintiff still had to go through multiple levels of appeal and a federal lawsuit to obtain relief.[138]

The medical necessity term is often the source of mistakes. In the *Wit* class action litigation, the court found that the administrator *never* used the required state standard, but then represented to regulators that it had, while knowing that those statements were false.[139] Likewise, an investigation by the New York Attorney General found that an administrator would deny claims based on purported lack of medical necessity, using the "fail-first" approach.[140] The "fail-first" criteria, however, appeared nowhere in the medical necessity criteria. Moreover, that approach was not followed with regard to medical and surgical claims.[141]

C. Aggressive Utilization Review

Utilization review is the ongoing review of benefit usage, usually with an eye to cost containment. Utilization review is often improperly aggressive with regard to mental health and particularly substance abuse disorder claims.

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135. *Id.* at *14.

136. Munnelly v. Fordham Univ. Faculty & Admin. HMO Ins. Plan, 316 F. Supp. 3d 714, 718 (S.D.N.Y. 2018).

137. The Interim Final Rules do not permit the exclusion of mental health benefits "in a classification (such as outpatient, in-network) in which it provides medical/surgical benefits" and that this amounts to "a limit, at a minimum, on the type of setting or context in which treatment is offered." Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5413 (Feb. 2, 2010) [hereinafter Interim Final Rules]; *see* Natalie V. v. Health Care Serv. Corp., No. 1:15-cv-09174, 2016 LEXIS 123783, at *7 (N.D. Ill. Sep. 13, 2016) (stating that "[t]he [Interim Final Rules] gave group health plan insurers . . . a heads-up that limitations on treatment settings were subject to the Parity Act") *cf.* Craft v. Health Care Serv. Corp., 84 F. Supp.3d. 748, 757 (N.D. 2015).

138. *Munnelly*, 316 F. Supp.3d at 724–26.

139. Wit v. United Behav. Health, No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205, at *176–77 (N.D. Cal. Feb. 28, 2019); *see also* Butler v. United Healthcare of Tenn., Inc., 764 F.3d 563, 566 (6th Cir. 2014) (stating that the administrator used the wrong medical necessity standard).

140. Assurance of Discountenance under Executive Law Section 63, Subdivision 15, ValueOptions, Inc., No. 14-176, 9 (2015) [hereinafter ValueOptions], https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf.

141. *Id.* at 10.

Payors may throw up additional barriers without any basis in the plan, as when an administrator required participants to exhaust their appeals of any previous claims before the participants could obtain authorization for any additional days or visits.[142] The settlement agreement notes the chilling effect this may have on participants seeking care: "[p]ersons with mental health and substance use disorders comprise a vulnerable population, and may be reluctant to seek care. Frequent and time-consuming utilization review may pose obstacles preventing them from accessing or completing treatment."[143]

The *Wit* class action lawsuit showed that concern for the high cost of inpatient treatment led to scrutiny of the average length of inpatient stay, attempts to decrease the average stay, and other strategies that would "mitigate" the financial impact of the Parity Act and keep benefit expenses low.[144] Even when internal committees recommended broadening coverage for the Applied Behavioral Analysis treatment for autism, the CEO vetoed the expansion and noted that "[w]e need to be more mindful of the business implications of guideline change recommendations."[145]

In addition, the Parity Law's prohibition on numerical limits on mental health coverage can result in a paradoxical effect. For example, the standard inpatient rehabilitation stay used to be twenty-eight days, but the Parity Law prohibits any quantitative limit (such as a numerical limit) on mental health and addiction treatment that is not equally applied to medical and surgical treatment.[146] Instead, then, insurers now approve as few as five days' treatment, with patients left to argue for more.[147] ValueOptions, for example, would approve small quantities of treatment: "just a few days or visits," according to the New York investigation.[148] The New York investigation uncovered instances of substance abuse treatment being approved just *one* day at a time. The agreement points out that "it is not possible to complete substance abuse rehabilitation treatment in one day."[149]

142. *Id.*
143. *Id.*
144. *Wit*, 2019 U.S. Dist. LEXIS 35205, at *195.
145. *Id.* at *193 (citing administrator's testimony).
146. D. Brian Hufford, *Insurers Have to Pay for Addiction Treatment. Trump Just Has to Enforce the Law*, WASH. POST (Nov. 8, 2017), https://www.washingtonpost.com/news/posteverything/wp/2017/11/08/why-wont-the-trump-administration-push-insurers-to-pay-for-treating-addiction/.
147. *Id.*; *see* ValueOptions, *supra* note 140, at 10.
148. *Id.*
149. *Id.*

D. Treatment of the Crisis, Not the Condition

To be effective, mental health and substance use disorder treatment should treat not just the immediate crisis but the underlying condition as well.[150] Coverage for mental health illness is improperly restricted when plan terms and their interpretation focus on the treatment of acute symptoms rather than the underlying condition.[151]

The *Wit* class action court concluded that the administrator's internal guidelines focused almost exclusively on the treatment of the immediate symptoms rather than the underlying condition.[152] The guidelines' language referred to the symptoms that caused a person to seek treatment, using terms such as "presenting problems," "presenting condition," and factors "precipitating" admission.[153] This focus on the "presenting problems" meant that the coverage did not extend to the individual's underlying condition once the acute symptoms were resolved.[154] The plaintiffs' denial letters also reflected that once the precipitating symptoms were resolved, further care was denied.[155] While the plans promised to provide coverage in keeping with generally accepted standards of care, the plans' focus on acute symptoms only was not, the *Wit* court found, consistent with generally accepted standards of care.[156] The court also noted an overall "drive to lower levels of care" as soon as the person could be moved.[157]

E. Failure to Provide Documents

Consumers often struggle to find out why their claims are denied. As set out above, health benefit plans are required to provide certain

150. The court in *Wit* cited the American Society of Addiction Medicine Criteria that stated, "[a]ddiction treatment services have as their goal not simply stabilizing the patient's condition but altering the course of the patient's disease toward wellness." Wit v. United Behav. Health, No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205, at *70 (N.D. Cal. Feb. 28, 2019).

151. Where payment guidelines focus on acute symptoms rather than underlying conditions, the result is "a significantly narrower scope of coverage than is consistent with generally accepted standards of care." *Id.* at *88.

152. *Id.* at *95–96 (stating that the administrator's treatment guidelines "restrict[ed] coverage to treatment necessary to alleviate the patient's most immediate symptoms"). The plaintiffs' denial letters reflected the same focus on immediate symptoms rather than the underlying condition. *Id.* at *90–91 (citing denial letters stating "[t]he crisis which led to [the member's] admission to acute facility based care has resolved" and that the member was "not exhibiting risk factors that require acute stabilization").

153. *Id.* at *92.

154. *Wit*, 2019 U.S. Dist. LEXIS 35205, at *98–99.

155. *Id.* at *90–91 (citing denial letters stating "[t]he crisis which led to [the member's] admission to acute facility based care has resolved" and that the member was "not exhibiting risk factors that require acute stabilization").

156. *Id.* at *214–15.

157. *Id.* at *126–27.

documents to beneficiaries. Courts interpreted the regulations as requiring the disclosure of "relevant documents, including medical opinion reports, at two discrete stages of the administrative process."[158] The DOL specified the definition of "relevant" documents, so as to clarify insurers' obligations but also to allow beneficiaries the information they need to determine whether to proceed further in the appeal process.[159] This is meant to provide claimants with information "necessary to determine whether to pursue further appeal."[160]

Despite the requirement that denials be clear, consumers may find them set out in conclusory boilerplate language rather than specifics.[161] Details of the medical necessity standard may be hard to find out unless the consumer is willing to litigate.

Yet to contest a claim denial, consumers need access to documents, but issuers often fail to follow the laws requiring disclosure. The problem with the disclosure requirement is that its violation often does not result in any particular harm to the defendant, despite a statutory provision allowing for a daily penalty for each day an administrator does not disclose documents after a request.[162]

F. Limited Networks

Another barrier to coverage for mental health treatment is the limited provider networks for mental healthcare. Without robust provider

158. *See, e.g.*, Metzger v. Unum Life Ins. Co. of Am., 476 F.3d 1161, 1161 (10th Cir. 2007) (citing 29 C.F.R. §§ 2560.503-1(h)(2)(iii), 2560.503-1(i)(5) (2021)) ("First, relevant documents generated or relied upon during the initial claims determination must be disclosed prior to or at the outset of an administrative appeal. Second, relevant documents generated during the administrative appeal—along with the claimant's file from the initial determination—must be disclosed after a final decision on appeal.").

159. ERISA Claims Procedure, 65 Fed. Reg. 70246, 70252 (Nov. 21, 2000) (codified at 29 C.F.R. pt. 2560).

160. *Id.*

161. ValueOptions, *supra* note 140, at 14 (stating that Emblem admitted that ValueOptions' denial letters "primarily state in general rather than specific terms why the member's condition does not meet medical necessity criteria" and that the letters were insufficient and often mischaracterizing the level of treatment requested).

162. *See* 29 U.S.C. § 1132(c)(1) (2021) (providing a penalty of $100 per day for each day a plan does not disclose requested documents); *see, e.g.*, Boyd v. Sysco Corp., No. 4:13-cv-00599-RBH, 2015 U.S. Dist. LEXIS 160576, at *44 (S.D.S.C. Dec. 1, 2015) (noting that the defendant United Behavioral Health "failed to comply with the procedural requirements of ERISA [in regard to document disclosure]" but denying request for attorney's fees and simply remanding case to the administrator for another review); Lukas v. United Behav. Health, 504 F. App'x 628, 630–31 (9th Cir. 2013) (noting that the defendant failed to provide a reason for the denial and did not disclose, upon request, file notes in its possession that contained a more complete explanation of its decision).

networks, consumers struggle to find care, as they will be required to pay higher rates for out-of-network coverage.[163]

Private health insurers' payments to providers for treatment are lower for mental health and substance use disorder treatment than for medical/surgical treatment.[164] Lower payments can discourage mental health and substance use disorder treatment providers from joining networks, especially where the out-of-network payment is no lower than in-network.[165] Between 2015 and 2017, the payment gap widened between provider payments for medical/surgical and those for mental health and substance use disorder treatment.[166]

The standards for admission to a provider network and the reimbursement rates are considered NQTLs and are therefore subject to the Parity Law, but mental health providers still report problems in joining networks.[167] The mental health networks may be limited, at least in part, due to onerous requirements for joining. In one study, for example, many mental health providers noted difficulties with joining mental health networks or simply being told that provider networks were closed to new applications from mental healthcare providers.[168] Other mental health providers cited low reimbursement levels and insurance companies' limitations on care as a reason they did not join health insurance networks.[169] Although the Parity Law does not require the same number of mental health and medical/surgical in-network providers, they do require that payors undertake equivalent processes to populate both types of networks.[170] Significantly different networks for mental health, as opposed to medical/surgical treatments, would be a red flag for a possible parity law violation.[171]

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163. *See* Kyanko et al., *supra* note 24, at 2.

164. *See* Ali Shana, *Mental Health Parity in the U.S.: Have We Made Any Real Progress?*, PSYCHIATRIC TIMES (June 16, 2020), https://www.psychiatrictimes.com/view/mental-health-parity-in-the-us-have-we-made-any-real-progress; *see, e.g.*, MELEK ET AL., *supra* note 12, at 6–7 (noting that the "average in-network reimbursement rates for behavioral health office visits are lower than for medical/surgical office visits . . . and this disparity has increased between 2015 and 2017.") As of 2017, reimbursements were 23.8% higher for primary care than for behavioral health, an increase from 20.8% in 2015. *Id.*

165. *See id.* at 13.

166. *Id.*

167. *See* FAQS PART 39, *supra* note 52, at 9.

168. *See, e.g.*, ILLINOIS REPORT, *supra* note 22, at 8. The report states that three out of four responding providers stated that procedures for joining health plans' networks were sometimes/often/always "unusually burdensome." Sixty-five percent of responding providers reported that they were often or always told that networks were closed to applications and nearly half said they were always told this. *Id.*

169. *See* Kyanko et al., *supra* note 24, at 2.

170. *See* FAQS PART 39, *supra* note 52, at 10.

171. *Id.*

G. Improper Use of "Fail-First" Protocols

Furthermore, many providers report that insureds face "fail-first" barriers, in which insureds must undertake a lower level of treatment than the requested treatment, and then fail at that treatment before the more intensive or expensive treatment will be authorized.[172] If these restrictions are applied to mental health conditions at a greater rate or intensity than to medical conditions, that difference violates the Parity Law.[173]

A limited network can also make compliance with a fail-first requirement impossible if there is no provider who provides the therapy that the plan is requiring before a more intensive level of therapy.[174] If the plan requires a less intensive level of therapy and the plan's applicable network does not include a provider that fits the requirement, then the plan violates the Parity Act.[175]

IV. PUTTING TEETH IN THE PARITY LAW

A law alone accomplishes little—only compliance with the law accomplishes the goal. Compliance with the mental health Parity Law can be expensive, demanding equal coverage and payment of claims that otherwise might not have been covered. Private health insurance companies exist in a commercial marketplace, aiming to create shareholder value and competing against one another for business—so if enforcement is not vigorous and widespread, then the companies who comply with the Parity Law are the ones who are penalized.[176]

This problem of strategic non-compliance and insufficient penalties, however, is not new. Two other landmark federal laws suffered from ineffective enforcement and lack of penalties until the problems they were designed to solve remained unsolved, even worsening. Both federal environmental and securities laws show how Congress has stepped up to provide the penalty and enforcement structure that proved insufficient in earlier iterations of the laws.

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172. *See* ILLINOIS REPORT, *supra* note 22, at 7 figure 4. Twenty-eight percent of mental health providers responding to a survey reported that commercial providers "often" required mental health insureds to fail first at a lower treatment level; twenty-seven percent of respondents reported that commercial payors "sometimes" required such treatment failures before approving the requested treatment. *Id.*

173. *See* FAQS PART 34, *supra* note 54, at 11.

174. *Id.*

175. *Id.*

176. The same was true of the environmental laws before. *See, e.g.*, David R. Hodas, *Enforcement of Environmental Law in a Triangular Federal System: Can Three Not Be a Crowd When Enforcement Authority is Shared by the United States, the States, and their Citizens?*, 54 MD. L. REV. 1552, 1552 (1995) (noting that if enforcement of the environmental laws is ineffective, then those local governments and companies "that comply with environmental laws are the ones being penalized, not the violators").

A. A River Ignites: The Environmental Example

The federal water quality laws evolved from weak penalties and enforcement to heavier penalties designed to remove the economic incentive for non-compliance and discourage future violations.[177] The clean water laws started out as mainly symbolic, with weak enforcement that required additional legislation to make it effective. Before 1972, the federal water pollution law was based on interstate water quality designations.[178] The law did not require dischargers to do anything specific, and enforcement was so difficult that the government did not attempt it frequently.[179] The laws focused on ambient water quality, and dischargers were only charged when the specific discharger could be linked to a change in the ambient water quality.[180]

When an Ohio river ignited due to high levels of pollution, the public demanded better enforcement. Ohio's Cuyahoga River contained such high levels of pollution that it was flammable and only then was the water so polluted that it was considered unusable under the existing regulations.[181] To charge a polluter, the government had to show a connection between the polluter and the water igniting.[182]

To provide greater accountability and enforcement with the water laws, Congress amended the Federal Water Pollution Control Act and enacted the Clean Water Act.[183] The law took a different approach to enforcement: instead of waiting for pollution to change the water quality, the law imposed minimum standards for water quality; state standards supplemented the law with specific requirements at the polluter's site.[184] The law required that polluters have a permit to pollute, and the permit imposed specific effluent limitations and requirements to report.[185]

In addition to more specific requirements imposed at the polluter's site, the law expanded enforcement. Previously, only the government

177. In 2019, federal and administrative fines for environmental violations totaled $471.8 million, 170 criminal cases were opened, and entities made commitments to reduce, treat, or eliminate $347.2 million pounds of waste. Press Release, U.S. Env't Prot. Agency, EPA Announces 2019 Annual Environment Enforcement Results (Feb. 13, 2020), https://www.epa.gov/newsreleases/epa-announces-2019-annual-environmental-enforcement-results.

178. Hodas, *supra* note 176, at 1554 (citing PETER CLEARY YEAGER, THE LIMITS OF LAW: THE PUBLIC REGULATION OF PRIVATE POLLUTION 78 (1991)).

179. *See id.*

180. *See id.*

181. *See id.*

182. *See id.*

183. *See* Hodas, *supra* note 176, at 1555 (citing Water Pollution Control Act of 1948, Pub. L. No. 845, § 758, 62 Stat. 1155 (1948) (codified as amended at 33 U.S.C. § 1251)).

184. *See id.* at 1556.

185. *See id.* (citing 33 U.S.C. § 1251(a)(7) (2021)).

could enforce the law. The Clean Water Act, however, expanded enforcement and enlisted the public's help.[186] The nation's waterways are so extensive; however, that enforcement had to be both straightforward and a genuine threat: a violation resulted from pollution without a permit or outside a permit's terms and triggered a potential injunction, civil penalties of up to $25,000 per day per violation, and criminal sanctions.[187]

In terms of remedies, the EPA's civil damages scheme is intended to recover the benefit that the offending company received from the infraction and to add further penalties, so the company is discouraged from committing further infractions.[188]

B. The Securities Laws Gain Enforcement Power

Like the federal environmental laws, the federal securities laws too faced an initial period of weaker enforcement followed by legislation that empowered the government to impose penalties and enlist the public in the enforcement effort. Once the Securities and Exchange Commission's (SEC) power to impose penalties and tougher enforcement was weak.[189] The SEC protects investors from fraud and ensures the financial markets' integrity.[190] Before the 1980s and 90s, however, the SEC's enforcement powers were limited, and the securities laws did not provide for penalties

186. *See* 33 U.S.C. § 1251(e) ("Public participation in the development, revision, and enforcement of any regulation, standard, effluent limitation, plan or program established by the Administrator [of the EPA] or any State under [the Clean Water Act] shall be provided for, encouraged, and assisted by the Administrator and the States").

187. *See* Hodas, *supra* note 176, at 1557 (citing 33 U.S.C. § 1319(b)–(c)(1) (2021)).

188. *See Basic Information on Enforcement*, U.S. ENV'T PROT. AGENCY, https://www.epa.gov/enforcement/basic-information-enforcement (last visited Apr. 30, 2021) ("Civil penalties, which the EPA applies for a range of violations, including water contamination and air pollution, aim to recover the financial benefit a company has reaped by breaking the law and to impose additional costs so that firms are deterred from doing it in the future."); Juliet Eilperin & Brady Dennis, *Civil Penalties for Polluters Dropped Dramatically in Trump's First Two Years, Analysis Shows*, WASH. POST (Jan. 24, 2019), https://www.washingtonpost.com/national/health-science/civil-penalties-for-polluters-dropped-dramatically-in-trumps-first-two-years-analysis-shows/2019/01/24/7384d168-1a82-11e9-88fe-f9f77a3bcb6c_story.html.

189. Barbara Black, *Should the SEC Be a Collection Agency for Defrauded Investors?*, 63 BUS. L. 317, 323 (2008) (quoting Colin S. Diver, *The Assessment and Mitigation of Civil Monetary Penalties by Federal Administrative Agencies*, 79 COLUM. L. REV. 1435, 1436 (1979)).

190. *See generally*, *What We Do*, U.S. SEC. & EXCH. COMM'N, www.sec.gov/about/what-we-do (last visited Apr. 30, 2021) (stating that the SEC enforces the securities laws on behalf of the sixt-six million Americans who invest in the securities markets). As of April 30, 2021, this statistic is no longer on the SEC website, however statistics show fifty-five percent of American adults invested money in the stock market in the United states from 1999 to 2020. *See SHARE OF AMERICANS INVESTING IN STOCK MARKET IN THE UNITED STATES FROM 1990 TO 202*0, STATISTA, https://www.statista.com/statistics/270034/percentage-of-us-adults-to-have-money-invested-in-the-stock-market/ (last visited Apr. 30, 2021).

or disgorgement of profits.[191] Enforcement of the securities laws was principally left to judicial proceedings, in which courts would impose "ancillary relief" such as policy or management changes and disgorgement.[192] Until 1984, the SEC had no broad authority to impose civil penalties on those trading in the stock market on inside information, and its enforcement provisions remained narrow.[193]

Without sufficient enforcement powers, insider trading and other illegality threatened the financial markets' integrity, growing to "disturbing levels of financial fraud, stock manipulation and other illegal activity in the U.S. markets."[194] As insider trading threatened the financial markets' integrity, Congress acted in 1984 and 1988 to strengthen the SEC's enforcement powers.[195] As enforcement continued to be weak, Congress in 1990 provided additional power for the SEC to maintain the financial markets' integrity.[196] The 1990 Act allowed the SEC to seek disgorgement as a remedy against those trading on inside information or to disseminate false and misleading information in the securities marketplace.[197] Disgorgement had already been available as a judicially-imposed remedy, but the 1990 Act provided this express power.[198]

The environmental laws are tied to the profits a company would have made on prohibited behavior; so too should insurance companies be subject to penalties that will counterbalance the temptation to avoid paying mental health and substance use disorder claims.

C. Toward a More Robust Parity Law: Verification, Consumer

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191. *See* U.S. SEC. & EXCH. COMM'N, *supra* note 190.

192. *See* James R. Farrand, *Ancillary Remedies in SEC Civil Enforcement Suits*, 89 HARV. L. REV. 1779, 1779 (1976) (discussing ancillary remedies that courts imposed on the defendants, including management changes, rescission, disgorgement, and others).

193. *See* Black, *supra* note 189, at 323; Stephen M. Cutler, Director, SEC Div. of Enf't, Speech by SEC Staff: 24th Annual Ray Garrett Jr. Corporate & Securities Law Institute (Apr. 29, 2004).

194. Cutler, *supra* note 193 (citing S. REP. NO. 101-337, at 1 (1990)).

195. *See id.* (first citing H. REP. NO. 98-355, at 1 (1983); then citing Insider Trading Sanctions Act of 1984, Pub. L. No. 98-376, § 2, 98 Stat. 1264 (1984); then citing Insider Trading and Securities Fraud Enforcement Act of 1988, Pub. L. No. 100-704, § 2, 102 Stat. 4677 (1988); and then citing Omnibus Trade and Competitiveness Act of 1988, Pub. L. No. 100-418, § 30A, 102 Stat. 1108 (1988)).

196. The Senate report on the 1990 legislation states that the purpose of Pub. L. No. 101-429 was to "provide the agency with a broader range of remedies to protect investors and maintain the integrity of the nation's security markets." S. REP. NO. 101-337, at 1 (citing Securities Enforcement Remedies and Penny Stock Reform Act of 1990, Pub. L. No. 101-429, § 201, 104 Stat. 936 (1990)). The House report concurs. *See* H.R. REP. NO. 101-616, at 9.

197. *See* S. REP. NO. 101-337, at 3, 8 (citing Securities Enforcement Remedies and Penny Stock Reform Act of 1990 § 101).

198. *See id.* at 9.

Assistance, Enforcement, & Penalties

The environmental laws and securities laws faced initial periods of lighter enforcement, which prompted increasingly robust enforcement legislation; the Parity Law should be amended to help consumers and make proper enforcement possible. Environmental enforcement laws were weak until the Cuyahoga River in Ohio caught fire, and citizens were shocked into demanding more. The opioid crisis is mental health parity's tipping point, showing that the Parity Law is not yet functioning the way it should. For both polluters and inside traders, the profit motive was irresistible until stronger penalties and enforcement counterbalanced it; the same is true of health insurers tempted to violate the mental health Parity Law.[199]

To be more effective, the Parity Law needs stronger enforcement. Before offering a plan on the ACA marketplaces or to employers, insurers should have to show and certify their compliance with the Parity Law. As consumers face claim denials, they should have widely available and further help with the appeal and litigation process. When a Parity Law violation is proven, insurers should be subject to fines, so compliance is more cost-effective than violation of the Parity Law.

1. Proactive Verification & Signature Certification

The burden of showing initial Parity Act compliance should fall on the plans themselves—the enforcement burden on government agencies is too great, and consumers are ill-equipped to spearhead the effort. As a baseline enforcement measure, health insurers are prohibited from selling policies, certificates, or contracts of insurance that do not comply with the Parity Law's provisions addressing aggregate and lifetime dollar limits, financial requirements, and treatment limitations.[200] This provision should be strengthened with a requirement that administrators submit not just forms but data and analysis supporting the conclusion that the plan complies with the Parity Law.

Step-by-step tools to demonstrate parity already exist and are part of the plan certification requirements in some states.[201] For plans governed

199. *See, e.g.*, Wit v. United Behav. Health, No. 14-cv-02346-JCS, 2019 U.S. Dist. LEXIS 35205, at *186–87 (N.D. Cal. Feb. 28, 2019) ("For fully-insured plans, [the administrator] bears the risk that the benefit expense for the services it approves will be more than it projected when it fixed its premium, which reduces [the administrator's] profit. Likewise, although [the administrator] does not bear the same risk with respect to self-funded plans, it has an incentive to keep benefit costs down for customers who purchase such plans").

200. The prohibition does not apply if the plan is exempt from the Parity Law due to the small plan exception or the increased cost exceptions. *See* 29 U.S.C. § 1185a (c) (2021).

201. Before the Federal Departments issued their compliance tool, leading advocacy organizations also published a six-step guide to self-assessment and compliance. TIM

by federal law, the Departments issued a six-step parity compliance tool that drills down on various non-quantitative treatment limitations.[202] To determine whether a non-quantitative treatment limitation is applied more stringently to mental health claims than medical and surgical claims, federal regulatory guidance suggests a comparison of outcomes data: numerical reimbursement rates, average denial rates, and appeal overturn rates.[203] While such rates do not indicate definite parity violations, "rates of denials may be reviewed as a warning sign, or indicator of a potential operational parity noncompliance."[204]

Plan administrators are the actors who are most familiar with their own data, and this analysis and submission of data would simply serve as confirmation of the existing parity requirement. And, just as the Sarbanes-Oxley Act of 2002 introduced a corporate officer certification requirement for certain financial disclosures, the Parity Law could

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CLEMENT ET AL., KENNEDY F., THE "SIX-STEP" PARITY COMPLIANCE GUIDE FOR NON-QUANTITATIVE TREATMENT LIMITATION (NQTL) REQUIREMENTS 1 (2017) (first citing 26 C.F.R. §§ 54.9812-1(c)(4)(i), 2590.712(c)(4)(i) (2021); and then citing 45 C.F.R. § 146.136(c)(4)(i) (2021)) ("[s]pecifically, this guide and spreadsheet establish a cohesive structure for performing these analyses in the context of the key terms within the final regulations found at 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), and 45 CFR 146.136(c)(4)(i).").

202. *See id.* at 2. The tool calls for the following steps: (1) the identification of the specific NQTL language and each service to which it applies, in each benefits classification; (2) the factors used to determine that the NQTL is appropriate for use with regard to mental health claims; (3) the evidentiary standard used to define each factor identified in Step 2; (4) identification of the comparative analysis used to conclude that the design and application of the NQTL as written is comparable to and applied no more stringently to mental health and substance abuse disorder benefits than to medical and surgical benefit; (5) provide the comparative analysis showing the same as Step 4, but in actual operation rather than as written. This proof could include peer review, clinical rationale used in approving or denying benefits, interpretation of plan language in approving or denying benefits and other forms of proof; (6) detailed summary explanation of how the analysis of all these processes and strategies and other factors shows that the plan or issuer concluded that the plan is in compliance. *Id.*

203. U.S. DEP'T OF LABOR ET AL., FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART VII) AND MENTAL HEALTH PARITY IMPLEMENTATION 2–3 (Nov. 17, 2011) [hereinafter FAQs ACA IMPLEMENTATION], https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-vii.pdf.

204. STEVE MELEK & STODDARD DAVENPORT, MILLIMAN, NONQUANTITATIVE TREATMENT LIMITATION ANALYSES TO ACCESS MHPAEA COMPLIANCE: A UNIFORM APPROACH EMERGES 2 (2019) (quoting U.S. DEP'T OF LABOR ET AL., SELF-COMPLIANCE TOOL FOR THE MENTAL HEALTH EQUITY ACT (MHPAEA) 17 (2020), https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf) (stating that NQTLs resulting in disparate outcomes "should be carefully examined").

include a company officer's signature certification of compliance with the Parity Law.[205]

To ensure that insurance company disclosures are accurate, the disclosures should be certified by an appropriate member of management. America has millions of ERISA plans, so the limited number of regulators cannot be expected to question and research all representations that plans make—the representations should come with a certification of correctness, backed by company officers.

The corporate officer certification requirement of the Sarbanes-Oxley Act of 2002[206] has resulted in company officers taking a more active role in ensuring that public company financial disclosures contain all material information and is correct.[207] This requirement resulted from calls for more accountability after corporate scandals and investor losses during the late 1990s and early 2000s.[208] The law requires that officers certify their responsibility for their company's controls, that they have evaluated the controls, and that the controls are designed to ensure that material information is made known to the officers during the reporting period.[209] The certification is tied to criminal penalties.[210] The certification requirement is largely viewed as a success, creating reform without undue burden on officers.[211] With the same certification requirement, the Parity Law, too, could become more robust, with company officers personally invested in mental health parity.

2. More Help for Consumers on the Front Lines

At present, consumers must tackle their denied claims largely alone. It is no wonder then, that most do not appeal or fight for payment, even

205. *See* Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, § 906, 116 Stat. 745 (2002) (codified in 15 U.S.C. §§ 78m(a), 78(o)(d)).

206. *See id.*

207. *See* Erin Massey Everitt, *Sarbanes-Oxley's Officer Certification Requirements - Has Increased Accountability Equaled Increased Liability?*, 6 DEPAUL BUS. & COM. L.J. 225, 245–46 (2008) (first citing Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, 116 Stat. 745 (2002); and then citing U.S. GOV'T ACCOUNTABILITY OFF., GAO-06-678, FINANCIAL RESTATEMENTS: UPDATE OF PUBLIC COMPANY TRENDS, MARKET IMPACTS, AND REGULATORY ENFORCEMENT ACTIVITIES 11–12 (2006)).

208. *See id.* at 225–26 (citing Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, § 302, § 906, 116 Stat. 745 (2002)) (noting that "countless corporate scandals" in the years leading up to 2001 resulted in investor outcry and calls for greater accountability among corporate officers. The officers had previously pleaded ignorance in the face of spectacular losses and scandals at some of America's largest companies.).

209. *See* 17 C.F.R. § 240.15d-14 (2021).

210. *See* 18 U.S.C. § 1350(c) (2021) (providing criminal penalties for officers who certify false financial statements with the penalty depending on the officer's mental state).

211. Everitt, *supra* note 207, at 246 (quoting that the certification requirement "strik[es] an impressive balance of substantive reform without undue burden on corporate officers").

when the denial is incorrect. Overwhelmed by the illness itself or the prospect of a time-consuming confrontation, few consumers appeal, if at all (less than one half of one percent of denied claims by one count), and even fewer continue past one level of appeal.[212]

Consumers need more help to navigate this process, in terms of information, practical assistance, and automatic external review. First, consumers need proper information on which to base an appeal. First, a plan's medical necessity criteria should be disclosed together with every denial, not simply on request. Advocates for those dealing with mental health and substance use disorder diagnoses report that many beneficiaries do not know they can request the medical necessity criteria or do not know how to access the criteria when they are disclosed online.[213]

Second, consumers should be able to access practical advice on the appeal process. While the federal government provides some resources for consumers seeking reversal of improper denials,[214] these seem insufficient, given the low number of claims that are appealed or taken to an external review.[215] The Department of Health and Human Services (HHS) has an online portal that can help people access mental health and substance use disorder treatment and information.[216] At present, however, the section for employer group health insurance states only that "[h]elp is available, if you have [b]een denied coverage, [r]eached a limit on your plan (such as copayments, deductibles, yearly visits, etc.), [h]ave an overly large copay or deductible."[217] The site does not guide readers

212. *See* Karen Pollitz & Daniel McDermott, *Claims Denials and Appeals in ACA Marketplace Plans*, KAISER FAMILY FOUND. (Jan. 20, 2021), https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/ (estimating that fewer than 1 in 20,000 denials is pursued to external appeal); *see also* POLLITZ, *supra* note 79, at 23, 24 (explaining that people with health insurance are often overwhelmed with the large number of medical bills they receive, unaware of the coverage they are entitled to, do not know they can appeal, and have little time to do so anyway).

213. *See* Letter from Richard Blumenthal, Connecticut Att'y Gen., and Kevin Lembo, Healthcare Advoc., to the Off. of Health Plan Standards and Compliance Assistance Emp. Benefits Sec. Admin. (May 28, 2009) (stating that medical necessity criteria should be disclosed automatically, so insureds and plan participants can prepare an appeal if necessary).

214. *See* SCALIA, *supra* note 85, at 9 (describing EBSA benefit advisors' efforts on behalf of individual claimants to resolve their Parity Law issues and refer problems for further investigation when needed).

215. *See* Pollitz & McDermott, *supra* note 212.

216. *See Mental Health and Addiction Insurance Help*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/programs/topic-sites/mental-health-parity/mental-health-and-addiction-insurance-help/index.html (last visited Apr. 30, 2021).

217. *Health Insurance and Mental Health Services*, MENTAL HEALTH.GOV, https://www.mentalhealth.gov/get-help/health-insurance (last visited Apr. 30, 2021) ("You may be protected by Mental Health and Substance Use Disorder Coverage. Parity laws require most health plans to apply similar rules to mental health benefits as they do for

toward any particular course of action or help. In addition, consumers can access a form to request Parity Law-related information from plans and insurers.[218] Consumers would benefit from a centralized phone number and ombudsman program, similar to that of the State of New York. The State of New York has created a consumer health care hotline and a behavioral health ombudsman program that centralizes the complaint system.[219] Furthermore, Congress should fund the Consumer Assistance Programs set out in the Affordable Care Act—these were established in 2010, but Congress has not appropriated funding for them since then.[220]

Third, an external review should be mandatory after two levels of appeal. Medicare has automatic external review, resulting in much broader use.[221] If external appeal were mandatory for private health insurance too, consumers could benefit from an outside opinion without spending time on figuring out how to navigate the process. In addition, external review results should be made public (without identifying information). At present, external review is at risk of inconsistent decision-making, as most states do not maintain a body of precedent decisions.[222] In addition, health insurers are repeat players in the system and, as such, have unfair advantages over consumers, who must navigate a complex system and who cannot recoup any attorneys' fees for that phase of the process, even if they later prevail in federal court.[223] With automatic external review and an established body of decisions,

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medical/surgical benefits. Select your insurance type below for more about the protections that apply for you, and to get assistance information. There are Federal and State Agencies who can provide assistance.").

218. The form is entitled "Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations." The form was last updated in April 2018.

219. *See* Lindsey Vuolo et al., *Evaluating the Promise and Potential of the Parity Act on its Tenth Anniversary*, HEALTH AFFS. (Oct. 10, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181009.356245/full/.

220. *See* Pollitz & McDermott, *supra* note 212 (citing CTRS. FOR MEDICARE & MEDICAID SERVS., SUMMARY OF CONSUMER ASSISTANCE PROGRAM GRANT DATA FROM OCT. 15, 2010 THROUGH OCT. 13, 2011 3)

221. *See* Weber, *supra* note 31, at 235 n.237 (citing Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Health Care*, 6 YALE J. HEALTH POL'Y L. & ETHICS 93, 140 (2006)).

222. *See id.* at 234 (first citing Hunter, *supra* note 221, at 138–40); and then citing Roy F. Harmon, *An Assessment of New Appeals And External Rev. Processes – ERISA Claimants Get "Some Kind Of A Hearing*," 56 S.D. L. REV. 408, 451 (2011)) (noting that procedural requirements like exhaustion of internal grievances process and adequate notice of process contribute to low rates of use, and that Medicare's automatic appeal process results in dramatically higher utilization. Also noting that there is a forty percent rate of reversal of internal decisions).

223. *See id.*

consumers could have better access and greater predictability of outcomes.

3. A Uniform Definition of "Medical Necessity"

For all stakeholders to understand when benefits are due, the guidelines for payment must be clear. The "medical necessity" term, found in most plans, is crucial because it must be met in order for treatment to be covered, whether for mental health or medical claims.[224] At present, each state or plan (if governed by federal law) can craft its own medical necessity definition and criteria, leading to a lack of consistency across plans and a lack of clarity about what will and will not be covered.[225]

A first step in addressing the uneven and often subjective application of this requirement would be to standardize the definition for plans governed by federal law, as many states have done. This would help with the inconsistency and lack of predictability that currently exist.[226] This definition could come from the Diagnostic and Statistical Manual of Mental Disorders (DSM). Health care providers, insurance companies, and some state parity laws already use the DSM's standards to define mental illness.[227]

4. More Active Enforcement & Penalties for Violations

For the Parity Law to be more broadly followed, the laws should be supplemented with more active enforcement and penalties. Civil penalties are a widely-used, even essential lever in the enforcement of regulations.[228] Civil penalties are so important to regulatory enforcement that some commentators find it "almost inconceivable" that Congress

224. *See id.* at 233.

225. *See* Letter from Heather R. Mermel, Senior Assoc. Pol'y & Program Dev., to Ctrs. for Medicare & Medicaid Servs. & Dep't of Health & Hum. Serv. (May 28, 2009) (on file with the Dep't of Lab.); *see also* Sage, *supra* note 116, at 601 ("[D]ecisions involving medical necessity are frequently characterized by inconsistent administration, poor communication, distrust, and, if disputes arise, relatively unprincipled, results-oriented judicial resolution.").

226. *See* Mermel Letter, *supra* note 225 (noting that standard medical necessity criteria, vetted by providers and consumers as well as other stakeholders, would provide greater certainty in coverage).

227. *See* Joni Roach, *Discrimination and Mental Illness: Codified in Federal Law and Continued by Agency Interpretation*, 2016 MICH. ST. L. REV. 269, 302 (2016) (citing AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013)).

228. *See* Colin S. Diver, *The Assessment and Mitigation of Civil Money Penalties by Federal Administrative Agencies*, 79 COLUM. L. REV. 1435, 1436 (1979) ([after becoming] [d]isillusioned with cumbersome criminal, injunctive, and license-removal sanctions students of regulation have increasingly turned to the civil fine in their search for a more effective enforcement device.").

would authorize a major regulatory program without accompanying penalties.[229] Penalties are used to motivate future behavior, encouraging conduct the government seeks to encourage and discouraging the opposite.[230] Penalties can be aimed at the entire group of actors the law is meant to affect, or may be focused on actors who have repeated the offending acts.[231] Another function of penalties is to compensate society for the offending behavior and to compensate the government for the costs imposed by infractions and by enforcement efforts.[232]

5. More Active Enforcement

Enforcement of the Parity Law relies on a small number of regulatory officials, but the bulk of the work in flagging violations and bringing them forward is done by consumers after the consumer suffers harm from an improper denial. This approach is inadequate in several respects. First, consumer-focused enforcement is reactive—consumers do not generally realize there is a problem until they suffer the consequences through improper denial. This approach is equivalent to the early enforcement approach of the water laws. The federal pollution law initially called for enforcement actions after pollution was released and resulted in certain levels of pollution in the water—that is, the damage was already done.[233] Likewise, current approaches to enforcement of the Parity Law wait until consumers suffer the harm, favoring those consumers with the wherewithal and resources to press their claims.

The ERISA claims and appeal process was meant to promote a low-cost and efficient means of settling claims.[234] The federal approach is not to sue issuers, but to work collaboratively, to educate and use voluntary compliance tools, and to correct plans.[235] But this assumes a desire to comply that is not always present, and leaves consumers to assert their rights.

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229. *See id.* ("[I]t is today *almost inconceivable* that Congress would authorize a major administrative regulatory program without empowering the enforcing agency to impose civil monetary penalties as a sanction.") (emphasis added).

230. *See id.* at 1455–56.

231. *See id.* at 1456.

232. *See id.*

233. *See* Hodas, *supra* note 176, at 1554 (citing YEAGER, *supra* note 178, at 78).

234. *See* Harrow v. Prudential Ins. Co., 279 F.3d 244, 249 (3d Cir. 2002) (quoting Amato v. Bernard, 618 F.2d 559, 567 (9th Cir. 1980)) (stating that one goal of ERISA is "to help reduce the number of frivolous lawsuits under ERISA; to promote the consistent treatment of claims for benefits; to provide a nonadversarial method of claims settlement; and to minimize the costs of claims settlement for all concerned."). *Id.*

235. *See, e.g.*, Press Release, U.S. Dep't Lab., U.S. Department of Labor Issues Proposed 2020 Self-Compliance Tool to Further Mental Health and Substance Use Disorder Parity Compliance (June 19, 2020) (on file with author) (offering voluntary compliance tools for issuers to determine whether they comply with the law).

For issuers that want to comply, the federal approach is helpful. To enforce the law with regard to more recalcitrant issuers, however, the New York State approach is more effective and should be a model for federal efforts. New York State has undertaken a vigorous parity enforcement program, reaching settlements with multiple carriers that have resulted in the payment of large fines as well as the payment of many previously-denied claims.[236] Soon after the passage of the New York state parity law, New York officials fined health insurance companies a total of $2.7 million for violating the law's notice provisions.[237] Then, the New York Attorney General's Office started investigating parity violations after a consumer hotline received a high number of complaints relating to mental health and substance abuse coverage, including residential treatment exclusions and medical necessity denials.[238] As a result of the actions, the New York State Attorney General's Office settled six enforcement actions, resulting in millions of dollars paid to consumers, changes in carriers' practices, and agreements that the carriers would provide additional data to the Health Care Bureau of the New York State Office of the Attorney General.[239] To bring these actions, the New York Attorney General relied on an executive law that gives the attorney general broad power to seek restitution, damages, or an injunction against continuing business operations, where a business is repeatedly breaking the law.[240]

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236. *See, e.g.*, Vuolo et al., *supra* note 219.

237. *See* Rick Karlin, *Timothy's Law Fines Total $2.7 Million*, TIMES UNION (May 8, 2012), https://www.timesunion.com/local/article/Timothy-s-Law-fines-total-2-7M-3544091.php#ixzz1uMypxigU.

238. *See* TARA ADAMS RAGONE & JOHN V. JACOBI, SETON HALL L. CTR. FOR HEALTH & PHARM. L. & POL'Y, THE PUZZLE OF PARITY: IMPLEMENTING BEHAVIOR HEALTH PARITY 2–3 (Jan. 2017) (citing emails from the New York Attorney General's Office explaining that the office used its general law enforcement statute to investigate compliance with both the New York and federal parity laws).

239. *See id.* at 3. Furthermore, as part of the Bureau's work, Cigna and Anthem agreed to stop requiring prior authorization for medication-assisted treatment for opioid use disorder. *Id.*

240. The New York State Executive Law authorizes the Attorney General, where there are "repeated . . . illegal acts" or "persistent . . . illegality in the carrying on, conducting or transaction of business," to seek relief, including enjoining the continuance of such business activity or of any illegal acts, as well as restitution and damages. *See* N.Y. EXEC. LAW § 63(12) (McKinney 2021). This law has long been recognized as giving broad powers to enforce state and federal laws. Eliza A. Lehner, *Dissenting by Enforcing: Using State Consumer Protection Statutes to Enforce Federal Law*, 12 HARV. L. & POL'Y REV. 209, 214–15 (2018) (quoting Oncor Commc'ns, Inc. v. New York, 626 N.Y.S.2d 369, 373 (Sup. Ct. 1995)).

6. Federal Damages & Penalties Should Be Available

The current ERISA enforcement approach focuses on making the plaintiff whole rather than punishing the defendant's conduct.[241] But this focus is individual, failing to address the systemic wrongs or the reality that only the tiniest proportion of people with improperly denied claims ever reach federal court and obtain a remedy. Where wrongs are not just individual but systemic, a broader approach is needed.

The Parity Law needs penalties to discourage profitable violations, just as the securities laws required penalties to discourage violations, where violations themselves would be profitable or where the cost of compliance could lead to violations.[242] A penalty for violation of the Parity Law need not be overly burdensome for the Departments to impose—most penalties are resolved without resort to a formal adjudicatory hearing.[243]

In 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis presented the administration with recommendations to combat the opioid crisis; it heard from numerous stakeholders regarding the status of the Parity Law and its enforcement.[244] The Commission recommended enforcement of the Parity Law through civil monetary penalties, similar to those for violation of the Genetic Information Nondiscrimination Act (GINA).[245] The Commission noted that the Parity Law is not currently enforced sufficiently and advised that the Department of Labor be given penalty authority "as a more meaningful deterrent against noncompliance."[246] In its own report to

241. *See, e.g.*, Varity Corp. v. Howe, 516 U.S. 489, 515 (1996) (noting that "where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief . . . ."); *see also* Rochow v. Life Ins. Co.,780 F.3d 364, 371 (6th Cir. 2015) (rejecting disgorgement remedy as supplement to claim payment, noting that "ERISA remedies are concerned with the adequacy of relief available to make [the plaintiff] whole, not the nature of the defendant's wrongdoing.").

242. *See* Black, *supra* note 189, at 323 (explaining that Congress intended the new securities law penalties to "deter unlawful conduct by increasing the consequences of securities law violations" and that penalties would "help deter conduct that would otherwise produce financial returns the violator," and "create additional deterrence for recidivist violators.").

243. *See* Diver, *supra* note 228, at 1437.

244. *See* PRESIDENT'S COMM'N, *supra* note 17, at 71 ("[t]he Commission heard from numerous organizations, such as the Parity Implementation Coalition, the Partnership for Drug-Free Kids, the National Council for Behavioral Health, Shatterproof, ASAM, and the American Academy of Addiction Psychiatry, about the need to systematically monitor and enforce [the Parity Law] to ensure parity in the coverage of mental health and addiction services.").

245. *See id.*

246. Press Release, U.S. Dep't of Lab., *supra* note 235. "The Affordable Care Act . . . requir[es] coverage of mental health and SUD services as an essential health benefit in individual and small group plans. However, while parity is a legal requirement, the existing

Congress, the DOL concurs with those recommendations.[247] A year after the Presidential Commission's recommendations, however, the administration reported on progress toward the Commission's recommendations—the update focused on reduction of opioid prescriptions and increases in the availability of naloxone prescriptions.[248] The update did not address progress toward enforcement of the Parity Act or any progress on the addition of penalties and greater enforcement of the law.

Without penalties, private health insurers can ignore other requirements with little consequence. A uniform medical necessity definition, for example, is useless without any consequence for using the wrong one—even when states have a uniform medical necessity definition, instances abound of claims being processed under the wrong standard.[249] When a claim is eventually paid after proceedings in federal court, the years of delay are devastating for families who have paid for treatment out of pocket in the hope of eventual reimbursement. The cost of inpatient mental health or substance abuse treatment are high, often in the tens or hundreds of thousands of dollars.[250]

If there is no penalty for non-compliance, insurers are emboldened to correct improper claims processing only under a judge's orders—and sometimes not even then.[251] In one case, the administrator refused to process a claim for alcohol abuse properly, even under the court's orders, prompting a scathing assessment: "[e]ven this deferential standard

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means of monitoring and enforcing the parity act are insufficient." PRESIDENT'S COMM'N, *supra* note 17, at 71.

247. *See* ACOSTA, *supra* note 90, at 25 (citing 42 U.S.C. § 300gg-26 (1996)).

248. AN UPDATE ON PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPOID CRISIS: ONE YEAR LATER 1 (2019).

249. In *Wit v. United Behav. Health*, for example, discovery revealed that in Texas, UBH had at times substituted its own more restrictive "medical necessity" standard for the required state standards, and in Rhode Island, UBH used a standard that was inconsistent with the required state standard. *See* 317 F.R.D. 106, 127 (N.D. Cal. 2016).

250. *See* L.P. v. BCBSM, Inc., No. 18-cv-1241, 2020 U.S. Dist. LEXIS 35239, at *4 (D. Minn. Jan. 17, 2020) (noting that the parents of the mental health patient paid $189,477.74 for inpatient treatment and sought reimbursement from BCBSM); *see also* Michael W. v. United Behav. Health, 420 F. Supp. 3d 1207, 1215 (D. Utah 2019) (noting that the denial of coverage caused the plaintiffs to incur over $88,000 in expenses).

251. In one case, a district court judge ordered United Healthcare to have a new outside reviewer consider new letters from physicians. Butler v. United Healthcare of Tenn., 764 F.3d 563, 567 (6th Cir. 2014). Contrary to this instruction, United Healthcare told the reviewers that they "should disregard or give little weight to the three [new] letters" because they "d[id] not provide any specific information regarding Janie Butler's condition on February 17–18, 2005" and were "not relevant to a determination [of] whether she met the criteria for residential treatment." *Id.* Affirming the district court's award of benefits, the court of appeals noted United Healthcare's "refusal to give Janie's benefits claim a fair review not once, not twice, but *three times*—in spite of clear instructions from the district court." *Id*. at 568.

exceeds United's grasp as we enter the ninth year of the insurance company's failure to provide coverage to its insured."[252] Despite the court's strong criticism, however, United Healthcare's actions resulted in the usual outcome for this type of claims processing, namely payment of the benefit that it should have paid in the first place.[253]

V. CONCLUSION

The Parity Law has made progress, but it is not yet achieving its goals. In the meantime, those with substance use disorder are receiving treatment more often through publicly-funded programs or not at all—private health insurance is contributing least of all to the opioid crisis, resulting in a significant shift to public funding and to out-of-pocket payment. Support for solutions to the opioid crisis is strong and bipartisan—the Comprehensive Addiction and Recovery Act, for example, passed with ninety-four votes in favor and one against.[254] The opioid crisis has been declared a national emergency and a high priority. With reform, further enforcement, and penalties, the Parity Law can help overcome the opioid crisis and achieve the mental health parity goals it set out to achieve.

252. *Id.*

253. *See id.* at 565. The lower court had imposed $99,000 in fines for United Healthcare's failure to disclose the applicable standard to the plaintiff, but that was reversed due to technical errors in the plaintiff's allegations. *See id.* at 570–71.

254. *See* Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-109, 130 Stat. 695 (2016). This law did not, however, address private health insurance.