

An Unfulfilled Promise: Ineffective Enforcement of
Mental Health Parity

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The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (“MHPAEA”)¹ was designed to improve access to mental health and substance use disorder benefits for millions of Americans. However, almost ten years later, genuine mental health parity—i.e., coverage for mental health and substance use conditions comparable to medical/surgical conditions—largely remains an unfulfilled promise.² Enforcement of the MHPAEA has been divided among numerous state and federal agencies, many of which have not taken substantial steps to ensure implementation of the federal parity law.³ As a result of minimal enforcement, consumers, unsure of either how to identify a parity violation

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1. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 26 U.S.C. § 9812 (2017); 29 U.S.C. § 1185a (2017); Public Health Service Act, 42 U.S.C. §§ 201, 300gg-5 (2017).

2. California is a rare example of a state enforcing mental health parity laws. Kathleen G. Noonan & Stephen J. Boraske, *Enforcing Mental Health Parity Through the Affordable Care Act’s Essential Health Benefit Mandate*, 24 ANNALS HEALTH L. 252, 253, 273 (2015). New York is also another rare example of “aggressive” enforcement of mental health parity. A.G. Schneiderman *Offers Assistance For Individuals And Families Seeking Substance Abuse and Mental Health Treatment*, N.Y. OFF. OF THE ATT’Y GEN. (May 11, 2016), <https://ag.ny.gov/press-release/ag-schneiderman-offers-assistance-individuals-and-families-seeking-substance-abuse-and-mental-health-treatment>.

3. State regulators have primary enforcement authority over individual and group plans, including Medicaid (HHS has secondary authority if it determines states have failed to substantially enforce MHPAEA), DOL and IRS have enforcement authority over employer-based plans (generally, these are subject to ERISA), and HHS has primary authority over non-federal government plans which have not opted-out of complying with MHPAEA. See Noonan & Boraske, *supra* note 2, at 264. See also Sarah Goodell, *Enforcing Mental Health Parity*, HEALTH AFFAIRS 4 (Nov. 9, 2015), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=147.

or what coverage they are entitled to by law, are tasked with reporting parity violations through a confusing appeals process.⁴ In many states, very few potential violations have been reported, giving state regulators an illusory justification for inaction. In addition, enforcing the MHPAEA through litigation has delivered limited success, leaving many consumers without the protections of the federal parity law.⁵ Mental health advocates and stakeholders have repeatedly voiced their concerns about lax implementation and enforcement of mental health parity, but the promise of parity has been—and remains—empty for many. This article seeks to identify the causes for ineffective enforcement of the MHPAEA, assessing the flawed or limited means of enforcing mental health parity that have sprung up in the absence of a strong regulatory framework (i.e., consumer complaints, internal appeals, and parity litigation). In addition, the article offers recommendations to improve enforcement of mental health parity by utilizing audits of health plans for compliance with the MHPAEA. However, until adequate resources and funding are allocated to the enforcement of parity, none of these approaches will succeed and many insured individuals will continue to face barriers in accessing mental healthcare.

I. THE PROMISE OF PARITY: BACKGROUND ON THE MHPAEA

Prior to the introduction of federal parity laws, health insurance issuers and employer-sponsored plans rarely offered coverage for mental health

4. See THE KENNEDY FORUM, NAVIGATING THE NEW FRONTIER OF MENTAL HEALTH AND ADDICTION: A GUIDE FOR THE 115TH CONGRESS 9, https://thekennedyforum-dot-org.s3.amazonaws.com/documents/9/attachments/The_New_Frontier_CongressGuide.pdf?1485267841.

5. ERISA, which codifies the requirements of MHPAEA, provides for a private right of enforcement. Gerald DeLoss et al., *Mental Health Parity and Addiction Equity Act Final Rules: Limited Enforcement Options Don't Overcome Unequal Treatment*, 7 J. HEALTH & LIFE SCI. L. 73, 98 (June 2014). Parity Litigation has been effective for MHPAEA violations involving residential treatment limitations. See, e.g., N.F. v. Sinclair Serv. Co., 158 F.Supp.3d 1239, 1261-62 (D. Utah 2016), *Craft v. Health Care Serv. Corp.*, 84 F. Supp. 3d 748, 753 (N.D. Ill. 2015), *S.S. v. Microsoft Corp. Welfare Plan*, 2015 WL 11251744 (W.D. Wash. 2015).

conditions that was equal or comparable to other medical conditions.⁶ More restrictive financial limitations and treatment limitations to mental health benefits compared to medical or surgical benefits were common.⁷ In addition, states' legislative responses to this disparity in coverage were largely inconsistent and inadequate.⁸ The MHPAEA was designed to ensure that if a health plan or issuer offered mental health coverage, any financial requirements or treatment limitations would not be applied in a more restrictive manner to mental health benefits than compared to other medical benefits.⁹ Group health plans or health insurance issuers are not required to offer mental health coverage; however, if plans or issuers provide such coverage, it must be in parity with medical and surgical coverage.¹⁰ The ACA further expanded the parity protections of the MHPAEA by including mental health among one of ten "essential health benefits" that must be included in any individual or small group plan.¹¹

The MHPAEA itself offered only a rough framework for determining whether mental health coverage was in parity with medical or surgical benefits; further regulation was required to articulate and implement genuine

6. Goodell, *supra* note 3, at 1.

7. Financial limitations include, for example, restrictions on the number of inpatient and outpatient days or annual and lifetime limits whereas treatment limitations could consist of separate prior authorization requirements. *Id.* at 2.

8. John V. Jacobi, *Mental Illness: Access and Freedom*, 16 HOUS. J. HEALTH L. & POL'Y 37, 54 (2016) ("The uneven nature of states' responses to inequity in coverage, as well the limits on state power to affect the growing self-insured market, led to federal parity protection.").

9. MHPAEA prohibits aggregate lifetime and annual limits on mental health benefits if the plan or coverage does not include such limit on substantially all medical and surgical benefits. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. § 300gg-26(a)(1)-(2) (2017). In addition, a group health plan or health insurance issuer may not apply separate financial requirements or treatment limitations on mental health benefits unless such restrictions are no more restrictive than the predominant requirements applied to substantially all medical and surgical benefits. 42 U.S.C. § 300gg-26(a)(3)(A).

10. 42 U.S.C. § 300gg-26(a)(1)-(3).

11. 42 U.S.C. § 18022; Jacobi, *supra* note 8, at 55-56 ("[in combination,] MHPAEA and the ACA extend parity protections to most large group plans, self-funded or insured, that choose to offer behavioral health coverage. . . as well as all individual and small group plans.").

parity.¹² Recognizing that plans and issuers have not provided as expansive mental health coverage as medical or surgical coverage for decades is clear; however, defining parity in such a way as to comprehensively prevent discrimination in mental health coverage continues to be difficult.¹³ Although the MHPAEA clearly requires that mental health and other medical benefits must be comparably covered, exactly how to perform this analysis for services unique to behavioral healthcare remained unclear.¹⁴ In November 2013, the Departments of Health and Human Services (“HHS”), Labor (“DOL”), and Treasury (“Treasury”) jointly released a final rule clarifying how to conduct parity analysis and determine whether plans or issuers are in compliance.¹⁵ Under the final rule, comparison between mental health benefits and medical or surgical benefits must be made with reference to one of six classifications of benefits: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient out-of-network; emergency care; and prescription drugs.¹⁶

Additionally, the final rule established a two-branched analysis for comparing mental health benefits to medical or surgical benefits if a plan or issuer offers mental health benefits. First, a plan or issuer may not apply any

12. DeLoss et al., *supra* note 5, at 77 (“The general framework of MHPAEA itself includes some discussion of advancing parity and equity, but does not offer a practical, straightforward methodology for comparing MH/SUD with medical/surgical benefits.”).

13. Nathaniel Counts et al., *What’s Confusing Us About Mental Health Parity*, HEALTH AFFAIRS BLOG (Dec. 22, 2016), <http://healthaffairs.org/blog/2016/12/22/whats-confusing-us-about-mental-health-parity/>.

14. Michael Ollove, *Enforcement of Mental Health Care Coverage Lacking*, PEW TRUSTS STATELINE (Jun. 3, 2016), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/06/03/enforcement-of-mental-health-care-coverage-lacking> (“How, for example, can you compare the treatment of chronic mental illnesses, such as schizophrenia or bipolar disorder, with physical disease such as diabetes or high blood pressure?”).

15. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240-01 (Nov. 13, 2013).

16. If a plan offers mental health benefits in any one of these classifications, mental health benefits must also be provided in the remaining classifications as long as medical/surgical benefits are provided in those classifications. 45 C.F.R. § 146.136(c)(2)(ii)(A) (2014).

financial requirements, or *quantitative* treatment limitations (“QTLs”),¹⁷ to a classification of mental health benefits if that limitation is more restrictive than the predominant (more than one-half) financial requirements or QTLs applied to substantially all (at least two-thirds) medical or surgical benefits in the same classification.¹⁸ Second, a plan or issuer may not apply *non-quantitative* treatment limitations (“NQTLs”)¹⁹ unless the deciding factors for the limitation “are comparable to, and are applied no more stringently than, the processes, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.”²⁰ Although disparate financial requirements and QTLs have largely been reduced, if not completely eliminated,²¹ NQTLs continue to be a major hurdle for implementing and enforcing parity.²²

II. BREAKING THE PROMISE: CAUSES OF INEFFECTIVE ENFORCEMENT OF THE MHPAEA

Despite the MHPAEA and subsequent regulation, the blackletter

17. “Financial requirements” include any deductibles, copayments, coinsurance, or out-of-pocket maximums but do not include either aggregate lifetime or annual dollar limits. “Quantitative treatment limitations” refer to any limitations on treatment expressed numerically. 45 C.F.R. § 146.136(a).

18. 45 C.F.R. § 146.136(c)(2)(i); 45 C.F.R. § 146.136(c)(3)(i)(A) (defining “substantially all” as at least two-thirds); 45 C.F.R. § 146.136(c)(3)(i)(B) (defining “predominant” as more than one-half).

19. NQTLs refer to all treatment limitations which cannot be expressed numerically and “otherwise limit the scope or duration of benefits.” 45 C.F.R § 146.136(a). Examples include medical necessity criteria; formulary design for prescription drugs; network tier design; standards for including providers in networks (including reimbursement rates); methods for determining usual, customary, and reasonable charges; fail-first policies (refusing to pay for more expensive therapies until a cheaper therapy is shown to be ineffective); exclusions for failing to complete a course of treatment; and geographic restrictions. 45 C.F.R. § 146.136(c)(4)(ii).

20. 45 C.F.R. § 146.136(c)(4)(i).

21. LUKE BUTLER ET AL., STATE OF PARITY REPORT 2 (Feb. 23, 2016), <http://scattergoodfoundation.org/sites/default/files/State%20of%20Parity%20Report%20FINAL.pdf>.

22. For example, in FY 2016, the majority (54.55%) of the 44 MHPAEA violations identified by DOL investigations of 191 plans involved NQTL violations. EMPLOYEE BENEFITS SECURITY ADMINISTRATION, FACT SHEET: FY 2016 MHPAEA ENFORCEMENT, <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2016.pdf> (last visited Apr. 27, 2017).

requirements of mental health parity have been largely unrealized for many Americans, who continue to experience more restrictive coverage for mental health conditions.²³ The framework of enforcement authority for the MHPAEA has allowed for inconsistent enforcement, with several agencies tasked with ensuring compliance for various types of plans or coverage.²⁴ As such, enforcement has been inconsistent at best and nonexistent at worst.²⁵ Although both federal and state regulators have roles in enforcing the MHPAEA, enforcement for the MHPAEA is largely left to state insurance commissioners, state Medicaid directors, and attorneys general; many of whom have not actively pursued efforts to inform consumers or hold plans and issuers accountable for compliance.²⁶ The DOL recently increased efforts to audit plans over which it has enforcement authority,²⁷ but the number and impact of these investigations have been minimal.²⁸ While HHS has the authority to enforce the requirements of MHPAEA for individual and

23. See THE KENNEDY FORUM, NAVIGATING THE NEW FRONTIER OF MENTAL HEALTH AND ADDICTION: A GUIDE FOR THE 115TH CONGRESS 9, https://thekennedyforum-dot-org.s3.amazonaws.com/documents/9/attachments/The_New_Frontier_CongressGuide.pdf?1485267841 (last visited Apr. 27, 2017) (“The Federal Parity Law has been in place for nearly a decade, yet insurance coverage for mental health and substance use disorder care is still more restrictive than coverage for other medical care. Health plans and issuers have simply shifted the way they suppress costs so that disparity is no longer in plain view.”).

24. See Goodell, *supra* note 3.

25. For example, state regulators in Alabama, Oklahoma, Missouri, Texas, and Wyoming do not think they have the authority under state law to enforce MHPAEA. *Id.*

26. Kenneth L. Davis, *Mental Health Parity Is a Serious Issue*, FORBES (Oct. 7, 2016, 8:00 AM), <http://www.forbes.com/sites/kennethdavis/2016/10/07/the-need-for-mental-health-parity/#79211f791a04>.

27. Sarah Roe Sise, *Mental Health Parity – Can a Plan Exclude Residential Treatment Facility Benefits? Federal District Court Says No*, THE NAT’L L. REV. (Mar. 6, 2016), <http://www.natlawreview.com/article/mental-health-parity-can-plan-exclude-residential-treatment-facility-benefits>; see also David A. Slaughter, *DOL Highlights Growth in MHPAEA Enforcement*, HR DAILY ADVISOR (Jan. 31, 2017), <http://hrdailyadvisor.blr.com/2017/01/31/dol-highlights-growth-mhpaea-enforcement/>.

28. Despite having authority over 2.3 million health plans, EBSA conducted 191 MHPAEA audits in FY 2016 and identified only 44 violations. EBSA, EBSA RESTORES OVER \$777.5 MILLION TO EMPLOYEE BENEFIT PLANS, PARTICIPANTS AND BENEFICIARIES, <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/factsheets/ebsa-monetary-results.pdf> (last visited Apr. 27, 2017); See EBSA, *supra* note 22 (noting that EBSA benefit advisors answered 112 public inquiries regarding MHPAEA compliance).

group plans if it determines a state has not substantially enforced parity, HHS has only stepped in for four states.²⁹ Therefore, overall enforcement has been limited.

Since most state and federal agencies have not aggressively enforced the MHPAEA, the burden for identifying violations and encouraging compliance has fallen on consumers. Requiring consumers to identify parity violations is unrealistic when consumers lack clarity regarding how to file an internal appeal with their insurer, which state or federal agency with which to file a complaint in the event an internal appeal is unsuccessful, and in obtaining mental health medical necessity standards and medical and surgical standards to conduct parity analysis. Many state regulators then perceive the low number of complaints as confirmation that there is little need to pursue aggressive enforcement of state or federal parity requirements.

III. FLAWED AND LIMITED ROUTES TO ENFORCING THE MHPAEA

Since state and federal agencies have not substantially enforced the federal parity law, consumers and advocates have tried other routes for pursuing compliance, with limited success. A consumer-driven model of enforcement is problematic for a host of reasons. This model requires extensive consumer education about identifying parity violations in order to be effective.³⁰ Additionally, consumers have to determine where to file a complaint with one of several state and federal agencies in order to hold plans and issuers accountable for a parity violation.³¹ Furthermore, if state regulators do not

29. HHS is currently enforcing MHPAEA in Missouri, Oklahoma, Texas, and Wyoming. THE MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY TASK FORCE, FINAL REPORT 15 (Oct. 2016), <https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf> [hereinafter TASK FORCE REPORT].

30. See SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., APPROACHES IN IMPLEMENTING THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT: BEST PRACTICES FROM THE STATES 9, HHS Publication No. SMA-16-4983 (2016), <http://store.samhsa.gov/shin/content/SMA16-4983/SMA16-4983.pdf> (“Consumer education . . . is essential in ensuring that consumers receive the benefits of the law.”).

31. See Laura Goodman, *Guidance for Advocates: Identifying Parity Violations & Taking*

take action, under this model the only remedy available is litigation – but only if the consumer has a plan subject to the Employee Retirement Income Security Act of 1974 (“ERISA”).³² However, these limited means of enforcement share a common flaw – they all place the primary burden on the consumer, instead of regulators or insurers, to guarantee compliance with the requirements of the MHPAEA. Enforcing the requirements of the MHPAEA through either internal appeals, complaints filed with regulators, or litigation has largely failed to achieve parity. Shifting the responsibility for and cost of enforcement onto consumers fails to ensure true mental health parity and must be replaced with regulator-driven enforcement to achieve true parity.

A. *Consumer Complaints and Internal Appeals*

The vacuum created by minimal state and federal enforcement of the MHPAEA has resulted in shifting the primary responsibility for identifying parity violations onto consumers.³³ However, expecting consumers to effectively identify and report violations is unrealistic for many individuals with serious mental illnesses, and can be just as impractical even for

Action, HEALTH L. ADVOCATES, <http://www.healthlawadvocates.org/tools/publications/files/0021.pdf> (last visited April 27, 2017). The 21st Century Cures Act addresses this issue by allowing consumers to file complaints on the HHS website. See MENTAL HEALTH AND ADDICTION INSURANCE HELP, <https://www.hhs.gov/mental-health-and-addiction-insurance-help> (last visited Feb. 17, 2017).

32. Joseph Friedman et al., *A Crystal Ball: Managed Care Litigation in Light of the Patient Protection and Affordable Care Act*, 27 HEALTH L. 1, 7 (Dec. 2014) (“Importantly, although litigation cannot arise specifically under the parity acts or PPACA provisions affecting mental health, mental health parity has been held by courts to be enforceable by ERISA and thus may be enforced by remedies provided under ERISA.”). For example, Joseph and Gail F. submitted three internal appeals with their employer-sponsored group health plan prior to filing suit under ERISA for denial of residential treatment for their daughter’s mental health condition. *Joseph & Gail F. v. Sinclair Services Co.*, 125 F.Supp.3d 1238, 1245–46 (D. Utah 2016).

33. GUIDE FOR THE 115TH CONGRESS, *supra* note 23, at 9 (“Right now, far too much of the burden [of] determining compliance falls upon consumers and their family members.”). See also TASK FORCE REPORT, *supra* note 29, at 13 (“We are keenly aware that parity is only meaningful if health plans properly implement its requirements. It’s only meaningful if consumers and providers understand how it works. And it’s only meaningful if there is appropriate oversight by both federal and state agencies.”).

sophisticated consumers.³⁴

Multiple barriers prevent consumers from even filing a complaint with the correct office or agency. For example, many consumers are unaware that certain denials of mental health benefits are a violation of federal parity law.³⁵ Despite more than twenty years of advocacy, legislation, and consumer education efforts, most individuals have not heard of such protections, could not define “parity,” and almost certainly would not know how to identify a potential violation.³⁶ Several consumer education campaigns, by state agencies³⁷ and advocacy groups³⁸ have tried to repackage mental health parity for consumers, but with limited success.³⁹ Additionally, identifying how to file an internal appeal with a plan or issuer is not always clear.⁴⁰ Furthermore, if a plan or issuer does not reverse its decision after an internal review, consumers face difficulty navigating which state or federal agency to file a complaint with depending on their plan or coverage.⁴¹ Lastly,

34. Jenny Gold, *Federal Panel Calls for Stricter Enforcement of Mental Health Care Parity Law*, NPR SHOTS (Oct. 31, 2016, 10:52 AM), <http://www.npr.org/sections/health-shots/2016/10/31/500056803/federal-panel-calls-for-stricter-enforcement-of-mental-health-care-parity-law>.

35. In a January 2011 survey, seven percent of Americans had heard of the term “mental health parity” and even fewer had heard of MHPAEA. *Your Mental Health: A Survey of Americans’ Understanding of the Mental Health Parity Law*, AM. PSYCH. ASS’N (Jan. 2011), <https://www.apa.org/news/press/releases/parity-law.pdf>.

36. *Id.*

37. For example, the Connecticut Insurance Department has created a consumer toolkit to assist individuals in navigating insurance coverage for behavioral healthcare. CONN. INS. DEP’T, CONSUMER TOOLKIT FOR NAVIGATING BEHAVIORAL HEALTH AND SUBSTANCE ABUSE CARE THROUGH YOUR HEALTH INSURANCE PLAN (Nov. 2013), http://www.ct.gov/cid/lib/cid/Behavioral_Health_Consumer_Tool_Kit.pdf.

38. See THE KENNEDY FORUM, PARITY RESOURCE GUIDE FOR ADDICTION & MENTAL HEALTH CONSUMERS, PROVIDERS AND ADVOCATES (2015), https://parityispersonal.org/media/documents/KennedyForum-ResourceGuide_FINAL_1.pdf.

39. The presidential task force specifically recommended improving consumer education indicating this continues to be an area with room for improvement. THE WHITE HOUSE, FACT SHEET, FEDERAL PARITY TASK FORCE TAKES STEPS TO STRENGTHEN INSURANCE COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS 1 (Oct. 27, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/10/27/fact-sheet-mental-health-and-substance-use-disorder-parity-task-force>.

40. See PARITY RESOURCE GUIDE, *supra* note 38.

41. Gold, *supra* note 34.

consumers might be tossed between state and federal agencies as they delay or decline to process the consumer complaint.

Even when a consumer can identify a violation and navigate the complaint process, there is no guarantee she will get access to the necessary information regarding the how a plan determines what is and is not considered medically necessary. Group health plans and health issuers have often considered medical necessity criteria to be proprietary information and declined to disclose such information necessary for parity analysis.⁴² In addition, benefit denials often fail to provide enough information for consumers to appeal the determination, which also result in evidentiary hurdles for any subsequent litigation.⁴³

When considering the substantial barriers consumers face to resolving parity violations through the complaint process, it is not surprising that many state regulators report they have not received many parity-related complaints.⁴⁴ Efforts have been taken by stakeholders⁴⁵ and, more recently, by legislators to create a one-stop-shop where all consumers—regardless of plan or issuer—can report potential parity violations.⁴⁶ Advocates in many

42. Counts et al., *supra* note 13.

43. Despite guidance from the DOL regarding what must be included in denial letters, detailed information is not always provided. See U.S. DEP'T OF LABOR, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 31, MENTAL HEALTH PARITY IMPLEMENTATION, AND WOMEN'S HEALTH AND CANCER RIGHTS ACT IMPLEMENTATION 11 (April 20, 2016), <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>. The DOL has expressly stated that issuers and plans may not decline to disclose medical necessity criteria because it has been characterized as proprietary or commercially valuable information. *Id.* at 5.

44. Alex Ruoff, *Mental Health Groups Taking Parity Fight to States*, BLOOMBERG BNA (Oct. 31, 2016), <https://www.bna.com/mental-health-groups-n57982082089/>.

45. The Kennedy Forum, a mental health and substance use disorder advocacy organization, recently released a website where consumers can register complaints and find resources about how to file complaints with the appropriate state or federal agency. THE KENNEDY FORUM, PARITY REGISTRY, <http://parityregistry.org/> (last visited Feb. 17, 2017). For a description of this tool see, Patrick J. Kennedy Appearances, *Patrick Kennedy Mental Health Parity Rights Video*, YOUTUBE (Oct. 20, 2016), <https://www.youtube.com/watch?v=8zkmmQAGnk0>.

46. The 21st Century Cures Act, on the recommendation of the Presidential Task Force, provided for a new website available through HHS where any consumer may file complaints or appeals for potential parity violations. See MENTAL HEALTH AND ADDICTION INSURANCE

states have adopted this approach to place pressure on state regulators and attorneys general to enforce the requirements of state and federal parity laws by providing data for improper benefit denials.⁴⁷ However, such an approach is a work-around solution, designed to make up for inadequate state and federal enforcement. Ultimately, requiring consumers to be primarily responsible for holding plans and issuers accountable is not a sustainable or equitable means of implementing the MHPAEA.⁴⁸

B. Parity Litigation

If a consumer has exhausted all internal appeals without success,⁴⁹ they may file an action against the plan or administrator for violating the MHPAEA—so long as the group health plan is subject to the ERISA.⁵⁰ The MHPAEA itself does not create a private right of action; however its protections are codified at Section 712 of ERISA,⁵¹ which gives beneficiaries and participants of ERISA plans a private right of action.⁵² As a result,

HELP, <https://www.hhs.gov/mental-health-and-addiction-insurance-help> (last visited Feb. 17, 2017).

47. Ruoff, *supra* note 44.

48. This concern was specifically voiced in a listening session held by the Mental Health and Substance Use Disorder Parity Task Force. MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY TASK FORCE, SUMMARY OF SECOND STAKEHOLDER MEETING 2 (May 17, 2016), https://www.hhs.gov/sites/default/files/PTF%20May%20listening%20session%20notes_Re-mediated.pdf (“Enforcement cannot rely on a complaint-driven and appeals process given the consumer/provider-insurance provider information gap.”).

49. Generally, beneficiaries are required to avail themselves of a plan’s internal review prior to filing a cause of action under ERISA. There is an exception to this exhaustion requirement if internal review procedures do not adequately allow for meaningful review and the beneficiary can demonstrate futility. *A.F. v. Providence Health Plan*, 157 F. Supp. 3d 899, 909 (D. Oregon 2016).

50. Plan participants and beneficiaries of ERISA plans may bring actions to recover benefits for alleged parity violations under § 502(a) of ERISA. 29 U.S.C. § 1185a(a)(1)(B) (2009). The plaintiff may challenge the basis for a denial of benefits or challenge the design of the plan itself. *See* 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, 593 (2014).

51. 29 U.S.C. § 1185a.

52. *See* DeLoss et al., *supra* note 5, at 98.

litigation has been largely limited to beneficiaries of ERISA plans.⁵³ It is unclear whether beneficiaries and participants of non-ERISA plan are also entitled to a private right of enforcement,⁵⁴ but state parity laws may provide a private right of action where the MHPAEA does not.⁵⁵ In addition, the success of litigating towards enforcement of the MHPAEA has been limited, since many cases have not survived motions to dismiss or summary judgment.⁵⁶ Furthermore, standing to bring such actions has been limited.⁵⁷

Beyond limitations in who may properly bring private actions for violations of the MHPAEA, this route of enforcement leads to uneven results with regard to parity. Since group health plans are subject to both state and federal parity laws, judicial interpretation could create entirely different standards of compliance for each type of health plan, resulting in disparate coverage for mental health services.⁵⁸ In addition, limiting enforcement of

53. See PARITY TRACK, <https://www.paritytrack.org/reports/federal-report/litigation> (last visited Feb. 19, 2017).

54. DeLoss et al., *supra* note 5, at 98 (“Because ERISA, and not MHPAEA, provides for private enforcement of the MHPAEA, beneficiaries and participants of non-ERISA plans may not be entitled to this same private right of enforcement.”).

55. See *Rea v. Blue Shield of California*, 172 Cal. Rptr. 3d 823, 826 (Ct. App. 2014) (alleging violations under the California Mental Health Parity Act). See also O.S.T. ex rel. G.T. v. BlueShield, 335 P.3d 416, 418 (Wash. 2014) (alleging violations under the Washington parity law). Both state laws included mandated coverage for mental health treatment, which MHPAEA does not specifically require.

56. Barnes & Worthy, *supra* note 50, at 594 (“To date [in summer 2014], no federal parity case appears to have made it past summary judgment.”). This statement continues to be accurate. See, N.Y. Psych. Ass’n, Inc. v. UnitedHealth Group, 798 F.3d 125 (2d Cir. 2015) (appealing a motion to dismiss); Am. Psych. Ass’n v. Anthem Health Plans, Inc., 821 F.3d 352 (2d Cir. 2016) (appealing a motion to dismiss).

57. See *New York State Psychiatric Ass’n, Inc. v. UnitedHealth Group*, 798 F.3d 125 (2d Cir. 2015), *cert. denied*, 136 S.Ct. 506 (2015). *But see* *American Psychiatric Ass’n v. Anthem Health Plans, Inc.*, 821 F.3d 352 (2d Cir. 2016). For a discussion of standing as a barrier to parity enforcement, see Jeremy Ard, *Unfavorable Opinion from the Second Circuit Holding Psychiatrists, Associations Lack Standing in Parity Case*, THE KENNEDY FORUM ILLINOIS (May 25, 2016), <http://thekennedyforumillinois.org/unfavorable-opinion-from-the-second-circuit-holding-psychiatrists-associations-lack-standing-in-parity-case/>.

58. For example, the Ninth Circuit held that the California Mental Health Parity Act required coverage of residential treatment for eating disorders; however, a subsequent California state appellate decision held that residential care was not covered under the same parity law. Paul Garcia, Note, *The Problem with Parity: An Analysis of the Confusion Surrounding the California Mental Health Parity Act*, 87 S. CAL. L. REV. POSTSCRIPT 38, 38 (2014).

parity to litigation forces consumers to shoulder the costs of enforcement.⁵⁹ Moreover, many of the same barriers consumers face with filing complaints and internal appeals also limit the initiation of parity litigation.⁶⁰ Further, parity litigation only offers a remedy when there has been a denial of benefits; if a treatment option is not offered in the first place, parity litigation offers no solution.⁶¹ In this way, litigation cannot effectively remedy issues with workforce shortages, network adequacy, and unfavorable reimbursement rates, all of which have a substantial impact of the availability of behavioral healthcare services.⁶²

IV. FULFILLING THE PROMISE: RECOMMENDATIONS FOR IMPROVED ENFORCEMENT

Congress recently enacted the 21st Century Cures Act (“Act”),⁶³ which includes the Helping Families in Mental Crisis Reform Act of 2016 and appears to expand enforcement of the MHPAEA by increasing federal regulators’ authority and means to require compliance. The Act increased Medicaid reimbursement by eliminating a prohibition against billing for mental health and primary care services on the same day.⁶⁴ Additionally, it gave clear statutory authority for the Secretaries of HHS, DOL, and Treasury to audit health plans to determine their compliance with mental health parity

59. DeLoss et al., *supra* note 5, at 105.

60. *See supra* Part III. A.

61. Counts et al., *supra* note 13 (“Most of the litigation around parity compliance centers [on] benefit denials. Because no one is being offered collaborative care, no one is being denied.”). In addition, when provider reimbursement is uncertain for innovative models of care, such as collaborative care models which integrate primary and behavioral care, there is little incentive for providers to adopt these newer models when MHPAEA is not effectively enforced. *Id.*

62. TASK FORCE REPORT, *supra* note 29, at 18, 20, 27.

63. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat 1033 (Dec. 13, 2016).

64. 21st Century Cures Act § 12000, Pub. L. No. 114-255, 130 Stat 1033 (Dec. 13, 2016). *See* Jason B. Caron et al., *Tackling the Growing Problem of Mental Health and Substance Use Disorders*, MCDERMOTT WILL & EMERY, 21ST CENTURY CURES: A CLOSER LOOK (Jan. 2017), <https://www.mwe.com/en/thought-leadership/publications/2016/12/21st-century-cures-tackling-mental-health>.

laws.⁶⁵ Further, the Act requires HHS to develop an action plan for improved coordination in enforcement efforts among state and federal agencies, including a timeline for when certain strategic objectives will be met.⁶⁶ The Act also requires additional guidance clarifying disclosure requirements and providing illustrative, de-identified examples of compliance and noncompliance with special emphasis on NQTLs.⁶⁷ However, in practice, the Act is unlikely alter the landscape of mental health parity because no additional funding was allocated to finance this increased federal enforcement.⁶⁸

The 21st Century Cures Act may result in increased enforcement, but it remains to be seen if federal agencies will more rigorously enforce the MHPAEA, or whether state regulators will take advantage of federal grants to bolster enforcement of state and federal parity laws. In addition, further guidance is needed to clarify disclosure requirements and NQTLs, to ensure NQTLs are not impermissibly used as a means of disproportionately denying coverage for medically necessary behavioral healthcare. Further, since the Act will be implemented under a new administration with an uncertain mental health policy, it is unclear how robustly the MHPAEA will be enforced in the coming years.⁶⁹

65. 21st Century Cures Act § 13001, 42 U.S.C. § 300gg-26(d)(1) (“In the case that . . . a group plan or health insurance issuer . . . has violated, at least 5 times, [the requirements of MHPAEA] . . . the appropriate Secretary shall audit plan documents for such health plan or issuer in the plan year following the Secretary’s determination in order to help improve compliance with such section.”).

66. 21st Century Cures Act § 13002(c)(4).

67. 21st Century Cures Act § 13001, 42 U.S.C. § 300gg-26(a)(6)(B)(i)(I), (a)(7)(A).

68. Richard Frank, *What the 21st Century Cures Act Means for Behavioral Health*, HARVARD HEALTH BLOG (Jan. 19, 2017, 9:30 AM), <http://www.health.harvard.edu/blog/21st-century-cures-act-means-behavioral-health-2017011910982/print/>.

69. Some concern has been voiced about the fate of mental health reform under the Trump administration, given that mental health has become a bipartisan issue in recent years. Michelle Chen, *Trump’s Obamacare Repeal Could Lead to a Mental-Health Crisis*, THE NATION (Jan. 18, 2017)

<https://www.thenation.com/article/trumps-obamacare-repeal-could-lead-to-a-mental-health-crisis/>. In particular, the repeal and replacement of the Affordable Care Act, including its essential health benefit provisions, could seriously weaken the enforcement of parity by no

The Act adopted recommendations of the Substance Abuse & Mental Health Services Administration (“SAMHSA”) and a presidential task force in granting the secretaries of the HHS, DOL, and Treasury the authority to audit health plans—both routinely and at random—for compliance with the MHPAEA.⁷⁰ Audits are a powerful tool under a regulator-driven model of parity enforcement in which plans are reviewed by regulators for compliance with federal parity law and further action may be taken in the event of a violation.⁷¹ Although limited by inadequate funding, state and federal audits—also referred to as market conduct examinations—have uncovered significant violations of the MHPAEA and corresponding state parity laws.⁷² The failure to sufficiently allocate funds for routine and targeted audits limits the DOL’s capacity to ensure compliance with the MHPAEA and deprives regulators of one of their most effective tools for enforcing parity.⁷³ When audits are not properly funded, state and federal regulators will only take action to conduct audits after enough consumer complaints have amassed, requiring more than inertia from these agencies.⁷⁴ Until audits are used proactively, not as an enforcement tool of last resort, it is likely that parity enforcement will continue to be consumer-driven and thus ineffective.

V. CONCLUSION

The language of the MHPAEA suggests that disparity in coverage for mental and physical health conditions has largely been eliminated, especially when combined with the essential health benefits requirements of the ACA.

longer requiring the inclusion of mental health services in health plans. Alex Ruoff, *Obamacare Repeal Likely a Setback for Mental Health, Opioid Crisis*, BLOOMBERG BNA (Mar. 7, 2017), <https://www.bna.com/obamacare-repeal-likely-n57982084849/>.

70. Caron et al., *supra* note 64, at 4. See BEST PRACTICES FROM THE STATES, *supra* note 30, at 1,10. See also FEDERAL PARITY TASK FORCE, *supra* note 39.

71. Gold, *supra* note 34.

72. GUIDE FOR THE 115TH CONGRESS, *supra* note 23, at 9.

73. PARITY TASK FORCE, *supra* note 39.

74. *Id.* (“Given current resources, Federal parity enforcement efforts to date have generally focused on investigating consumer, provider and other parity complaints.”)

However, in practice, many disparities persist as a result of minimal enforcement by state and federal agencies specifically tasked with implementing the MHPAEA. Inaction by underfunded or ambivalent agencies has resulted in a vacuum where consumers, not regulators, must lead the charge in securing their right to parity under the MHPAEA. Yet consumers are more likely encounter confusion, difficulty, and external barriers when they seek to remedy parity violations either by internal appeals, complaints filed with regulators, or litigation. The 21st Century Cures Act, on its face appearing to fill in gaps in guidance and expand federal enforcement, may not be the answer when no additional funding has been allocated to that purpose. In order to achieve parity, the primary responsibility for enforcement must shift back to state and federal regulators, who should take a proactive role in the enforcement of the MHPAEA. Auditing plans for compliance and publicly disclosing non-confidential results of enforcement action are powerful tools for enforcement which should be pursued; however, the capacity for this enforcement tool is limited by funding and requires a political will to address disparities in mental health coverage.