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MHPAEA & Marble Cake: Parity & the Forgotten Frame of Federalism

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INTRODUCTION

In 2018, the U.S. Department of Health and Human Services ("HHS") estimated that 20.3 million people in the United States suffered from a substance use disorder ("SUD").[1] Of those people, 18.9 million did *not* receive treatment.[2] According to individuals with SUD, a major barrier to treatment is the inability to pay for treatment services.[3] While 34 percent of those surveyed reported lack of health insurance as a major contributing factor to their inability to pay, 8 percent were insured but reported that their insurance coverage did not cover SUD treatment.[4] Addressing the inability to pay for treatment is key to increasing access to treatment and decreasing the number of drug overdoses plaguing our nation.

The types of policy proposals available to provide funding for healthcare services, like SUD treatment, vary depending on the structure of the nation's healthcare system.[5] In the United States, healthcare services are largely provided by private actors, and these services are funded through a mixture of private health insurance

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1. U.S. DEP'T OF HEALTH AND HUMAN SERVS. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., HHS PUBLICATION NO. PEP 19-5068, KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2018 NATIONAL SURVEY ON DRUG USE AND HEALTH?2 (2019), https://bit.ly/2SDx4ju [https://perma.cc/78C4-T26M].

2. *Id.* at 54.

3. *Id.*; *see also* WILLIAM L WHITE, SLAYING THE DRAGON: THE HISTORY OF ADDICTION TREATMENT AND RECOVERY IN AMERICA 432 (2d ed. 1998) (summarizing additional barriers to access).

4. *Id.* at 432.

5. Healthcare systems are typically classified into four types: (1) the Beveridge Model, (2) the Bismarck Model, (3) the National Health Insurance Model, and (4) the Out-of-Pocket Model. In the Beveridge Model, the government provides and finances health care through taxing. The Bismarck Model insurers are usually financed by employers and employees through payroll deductions and must cover everyone which allows for little to no profit for the insurers. The National Health Insurance Model is made of up payments by all citizens to a publicly run insurance company that then pays for private sector providers. The Out-Of-Pocket Model is known as the "pay-to-play" model, where only those with money are able to pay for health care while the poor stay sick or die. Mimi Chung, *Health Care Reform: Learning from Other Major Health Care Systems*, PRINCETON PUB. HEALTH REV. (Dec. 2, 2017), https://bit.ly/2PgBLye [https://perma.cc/SPM2-Y2A2]. The United States has a private healthcare system, financed by private health insurance or public health insurance. Public health insurance is provided only to eligible persons that fall within statutorily defined categories, which can differ by state. While the majority of the public in the United States receives care from private providers, military personnel and military veterans receive government provided health care through the veterans' administration. *Id.*

and out-of-pocket expenses, with public health insurance programs covering only 35.9 percent of the population.[6]

For much of history, U.S. private insurers have not covered SUD treatment on par with physical health benefits, and federal guidelines did not require major public health insurance programs, like Medicaid,[7] to cover these services.[8] Prior to the 1980s, private insurers often excluded SUD treatment from coverage altogether. During the 1980s, there was a move by private insurers to cover SUD treatment more generously,[9] but such coverage soon gave way

6. Sixty-seven percent of Americans are enrolled in private health insurance. *The U.S. Health Care System*, THE COMMONWEALTH FUND, https://bit.ly/2wEAVEU [https://perma.cc/QM7S-LAQR] (last visited Feb. 22, 2020). Public insurance comes in three forms: Medicaid, Medicare, and the Children's Health Insurance Program ("CHIP"). Medicaid is jointly funded by the federal and state governments but is administered by the state. Richard Frank & Thomas McGuire, *Health Care Financing Reform and State Mental Health Systems*, *in* HEALTH, POLICY, FEDERALISM, AND THE AMERICAN STATES, 138–39 (Robert F. Rich & William D. White eds., 1996). Eligibility for Medicaid differs by state and is tied to income. *Medicare vs. Medicaid: What's the Difference?*, BENEFITS.GOV (Nov. 24, 2019), https://bit.ly/2A8BI2N [https://perma.cc/2VCK-QBCK]. Medicare, on the other hand, is an entitlement program through which all Americans can qualify by paying wage taxes and reaching the statutory age. Applicants can also qualify for Medicare if they have a qualifying disability. Juliette Cubanski et al., *A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers*, KFF (Mar. 20, 2015), https://bit.ly/2W8x3Gi [https://perma.cc/RUJ2-5AWQ]. Medicare is administered by the federal government. *Dep't of Health & Human Servs. (HHS)*, HEALTHCARE.GOV, https://bit.ly/3cb6VAp [https://perma.cc/T53Z-SRY4] (last visited Feb. 22, 2020). However, the federal government has delegated servicing of the plans to private insurers. *Health Insurance Exchanges Under the Affordable Care Act: Governance Options and Issues*, NAT'L ASS'N OF INS. COMM'RS 1, 2–3 (2011), https://bit.ly/2V9R9QF [https://perma.cc/FK7G-W62V]. Under the Affordable Care Act ("ACA"), CHIP has been folded into Medicaid. CHIP, which is administered by the states and jointly funded by the states and the federal government, provides health insurance to children from families with low-incomes. Robin Rudowitz et al., *Children's Health Coverage: Medicaid, CHIP, and the ACA*, KAISER FAM. FOUND. (Mar. 26, 2014), https://bit.ly/2wwjCpl [https://perma.cc/7GDE-6484].

7. See *Who is Eligible for Medicaid?*, HHS.GOV, https://bit.ly/2yywblw [https://perma.cc/C6F9-M5CL] (last visited Feb. 22, 2020). for an explanation of who qualifies for Medicaid. *See also* Frank & McGuire, *supra* note 6, at 137–40 (discussing how mental health benefits have been financed historically and stating that mental health benefits were often optional benefits that states could elect to include, but were not mandated to include); A. Thomas McLellan & Kathleen Meyers, *Contemporary Addiction Treatment: A Review of Systems Problems for Adults and Adolescents*, 56 BIOLOGICAL PSYCHIATRY 764, 768 (2004).

8. Amanda J. Abraham et al., *The Affordable Care Act Transformation of Substance Use Disorder Treatment*, 107 AM. J. OF PUB. HEALTH 1, 31–32 (2017).

9. According to White, in the 1980s, employers began to realize that coverage of SUD treatment may increase worker productivity and therefore adjusted their insurance policies to include SUD treatment. *See id.* at 395–400. Employers' willingness to cover SUD treatment was supported by the recent program accreditation and credentialing of alcohol use disorder treatment. *Id.* 382–84.

to requirements for pre-approval, "failed first," maximum annual or lifetime benefits, and other restrictions.[10] While some states enacted legislation to improve private insurance coverage of SUD treatment, states did so in varying degrees.[11] Policy entrepreneurs[12] pushed for federal legislation because of states' failures to consistently require private insurers to cover SUD benefits at parity, or equal to, physical health benefits and because federal legislation preempted state regulation over some employer-sponsored health plans.[13] It took legislators decades to incrementally enact federal legislation, which required some insurers to cover SUD treatment benefits at parity with physical health benefits ("federal parity legislation"); but in doing so, federal legislators encroached upon an area that has traditionally fallen to the states to regulate.[14] Further complicating matters, the federal agencies tasked with enforcing federal parity legislation delegated this authority to the states.[15] Some states explicitly refused to enforce federal parity provisions, arguing it was not the responsibility of state insurance commission-

10. Unfortunately, with the increase in insurers willing to pay for treatment, SUD treatment facilities grew in great number, and there was little oversight and regulation of these facilities—leading to a great disparity between the quality of services provided. *See* White, *supra* note 3, at 396–98. Further, the cost of such treatment grew. *Id.* Insurers reported that they were uncertain about how to gauge the medical necessity of some of these treatments and how to combat the corruption growing in some of the addiction treatment facilities. *Id.* at 398–99. To combat these escalating costs, most insurers created utilization review teams and managed care program oversight; some started requiring pre-approval for substance use treatment. *Id.* at 400–01. The managed care programs of the 1990s were largely seen as a financial backlash to the excesses of 1980s. *Id.* at 399. The primary responsibility of the utilization review teams was to determine whether or not the requested treatment with "medically necessary." *Id.* But due to the lack of professional guidelines at the time, the process was extremely subjective and resulted in unnecessary denials of care. *Id.* Treatment limits that limited the number of days or the type of treatment became more commonplace. *Id.* SUD treatment often had separate cost sharing, deductibles, or limits, including treatment day or visit limits. *Id.* These limitations existed despite the lack of their existence for chronic medical physical disorders diseases and were often more stringent and burdensome for SUD treatment than for physical health benefits. *Id.*

11. *See, e.g.*, McLellan & Meyers, *supra* note 7, at 768.

12. "Policy entrepreneurs are energetic actors who engage in collaborative efforts in and around government to promote policy innovations." Michael Mintrom, *So You Want to be a Policy Entrepreneur?*, 2 POL'Y DESIGN AND PRAC. 1, 1 (2019).

13. *See infra* Section III for a discussion of preemption. The federal Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") provided parity protections to 113 million people, many of whom were excluded from state law protections. Margo L. Rosenbach et al., *Implementation of Mental Health Parity: Lessons from California*, 60 PSYCHIATRIC SERVS. 1589, 1589 (2009).

14. This statement is expounded upon in Section III.

15. This statement is expounded up on Section III.

ers to enforce federal laws[16] and in doing so showed the degree to which federalism would affect the implementation and enforcement of federal parity laws.

Federal parity laws and their state equivalents ("parity laws") have increased access to SUD treatment by decreasing the cost borne by the insured, while only marginally increasing health plan costs.[17] Despite these improvements, the effects of parity on access to SUD treatment have been lower than expected. Recent reports suggest that states differ in the degree to which they enforcement parity laws,[18] which may explain why persons surveyed still report having inadequate insurance coverage for SUD treatment despite the enactment of parity laws. While other articles have offered suggestions for improving parity, most have lumped mental health and SUD treatment coverage together in their analysis and recommendations. This Article focuses exclusively on SUD treatment and its distinct institutional history.

In addition to its focus on SUD treatment, this Article contributes to the literature by analyzing parity implementation through the lens of federalism. In doing so, it demonstrates that the division of federal and state responsibilities has contributed to failures in implementation and enforcement. Further, this Article argues that parity implementation efforts must account for the current ideological divide that has characterized intergovernmental relationships.[19] In doing so, this Article suggests alternate structures for dividing the responsibilities for enforcement.

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16. Oklahoma, Texas, Wyoming, and Missouri have refused to enforce federal parity laws. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 ENFORCEMENT REPORT 1 (2018), https://go.cms.gov/2HMHrvz [https://perma.cc/34YW-A32F].

17. Rosenbach et al., *supra* note 13, at 1590; *see, e.g.*, Dhaval Dave & Swati Mukerjee, *Mental Health Parity Legislation, Cost-sharing, and Substance-abuse Treatment Admissions*, 20 HEALTH ECON. 161, 161 (2011). Note: studies that report mixed results in the increases to access due to parity include measurements for access to both SUD and mental health treatments. When SUD treatment access is analyzed separately, the results demonstrate that parity has indeed improved access. *See also* Hefei Wen et al., *State Parity Laws and Access to Treatment for Substance Use Disorder in the United States: Implications for Federal Parity Legislation*, 70 NAT'L INSTS. OF HEALTH 6 (2013), https://bit.ly/2SoaFa8 [https://perma.cc/2BWF-YKJT].

18. *The Mental Health Parity and Addiction Equity Act 10th Anniversary*, PARITYTRACK, https://bit.ly/3cd73iL [https://perma.cc/W7CD-MG7B] (last visited May 5, 2020).

19. Intergovernmental relations refers to the collaboration between levels of governments in a federal system to implement public policies. Philip Rocco, *Making Federalism Work? The Politics of Intergovernmental Collaboration and the PPACA*, 37 J. OF HEALTH & HUMAN SERVS. ADMIN. 412, 415 (2015).

I divided this Article into three parts. In Section I, I review theories of federalism from the social sciences literature and provide commentary on their usefulness in studying the state implementation of federal law in the context of parity. I focus my analysis on social science theories of federalism because unlike much of the legal scholarship on federalism, which focuses on the constitutional basis for divisions of responsibilities between governments, the social sciences scholarship focuses on the optimal structuring of intergovernmental relationships to achieve more effective implementation and enforcement of the law.

In Section II, I provide a contextual overview of the division of powers of insurance regulation. I support my conclusions with content and legal analysis of federal legislation, rules, cases, and administrative guidance on parity.[20] In Section III, I demonstrate how federalism continues to present opportunities and barriers to implementation and enforcement by providing the results of my empirical analysis[21] of state attempts to enforce federal parity laws.

I. THEORIES OF FEDERALISM IN INTERGOVERNMENTAL RELATIONS

This Section is by no means intended to be a complete literature review of the existing theories of federalism. Rather, this Section provides the reader with an overview of the most relevant theories of federalism, as well as developments in recent theories that address current partisan politics. The order in which the theories of federalism is presented does not reflect the order in which these theories developed in the literature.[22] The theories of feder-

20. My corpus of documents included a snowball sample of documents from the Executive branch, including the Departments of Labor, Health and Human Services, and Treasury, the National Institute on Mental Health and the Substance Abuse and Mental Health Agency, as well as congressional hearing notes. I also reviewed a selection of publications by advocacy organizations, such as the National Conference of State Legislatures, the National Alliance of Mental Illness, the Kaiser Family Foundation, and articles from news media outlets.

21. A subset of my analysis was an empirical content analysis of 112 state government documents, including administrative guidance, statutes, and regulations which populated when using the search terms "Mental Health Parity and Addiction Equity Act" in WestlawNext searching all states. Of these documents, 42 were implementing or enforcing documents. I defined an implementing document as one which simply implemented the MHPAEA. Most of the implementing documents stated that insurers must comply with MHPAEA and effectively allocated power to their state administrative agency to enforce MHPAEA. Enforcement documents created mechanisms to ensure compliance with MHPAEA. Such documents may include penalties, review processes, or filing requirements.

22. In fact, competitive federalism is said to have emerged in response to cooperative federalism, after theories of cooperative federalism were said to shift

alism have been presented this way to allow for the best transition between concepts relevant to this Article. Throughout my review of the theoretical literature, I explain the theories' particular relevance for parity implementation and enforcement.

In contemporary scholarship, American federalism is defined as the division of powers between the federal and state governments.[23] Federalism involves the allocation of policymaking, the administration of policies, and the financing for these policies.[24] In determining which level of government should be tasked with administering or enforcing legislation, the issues that arise are typically centered around capacity and the appropriate role, or scope, of government.[25]

II. THEORIES OF FEDERALISM

A. Dual Federalism

Many students of the law are familiar with the concept of dual federalism. Dual federalism suggests that federal, state, and local governments should operate within completely separate spheres of governance, with little to no overlap.[26] The U.S. Constitution is interpreted as allocating specific and enumerated powers to the federal government while reserving the remaining powers to the states and the people.[27] However, the Supreme Court's "liberal" interpretation of the federal government's power to regulate "interstate commerce" from the 1960s until the early 1990s expanded the federal government's power to domestic areas traditionally regulated by the states.[28]

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power from the state to federal government. Robert Agranoff, *Managing within the Matrix: Do Collaborative Intergovernmental Relations Exist?*, 31 PUBLIUS 31, 43 (2017) (noting that cooperative federalism arose between dual federalism and coercive federalism, which then elicited calls for decentralization of powers).

23. *See, e.g.*, Martin Diamond, *The Federalist on Federalism: Neither a National nor a Federal Constitution, but a Composition of Both,* 86 YALE L.J. 1273, 1273 (1976).

24. Robert F. Rich & William D. White, *Health Care Policy and the American States: Issues of Federalism*, *in* HEALTH, POLICY, FEDERALISM, AND THE AMERICAN STATES, *supra* note 6, at 10 [hereinafter *Issues of Federalism*].

25. *Id*. at 11.

26. *See* Kristen H. Engel, *EPA's Clean Power Plan: An Emerging New Cooperative Federalism?*, 45 PUBLIUS 452, 461 (2015) [hereinafter Engel, *New Cooperative Federalism*].

27. *See* THE FEDERALIST NOS. 10, 51 (James Madison); *see also* U.S. CONST. amend. X.

28. For a short history of federal expansion into health insurance regulation, see generally Michael S. Sparer et al., *Inching Toward Incrementalism: Federalism, Devolution, and Health Policy in the United States and the United Kingdom*, 36 J. HEALTH POL. POL'Y & L. 33 (2011).

Scholar Martin Grodzins argues, however, that the theory of dual federalism does not accurately characterize the division of powers in the American system of governance.[29] He likens dual federalism to a layer cake with each level of government functioning as a layer of the cake. Each layer is distinctly separate, representing a clear division between federal and state responsibilities.[30] The American system of government, he argues, is more like a marble cake, with the swirls of chocolate and vanilla cake representing the concurrent and shared jurisdiction over many policy domains by the federal, state, and local governments.[31] As will be discussed *infra*, health insurance regulation is a policy domain that is best explained by using both the layer and marble cake analogies; federal legislative reforms in the 1960s created exclusive federal jurisdiction over some employer-sponsored health care plans (the layer cake) and shared jurisdiction over other plans (the marble cake). If dual federalism is akin to a layer cake, competitive and cooperative federalism theory (reviewed below) can be described as a marble cake.[32]

B. Competitive Federalism

Competitive federalism is based on economic theories of markets[33] and suggests that competition between the state governments results in the development of the most effective and cost efficient policies.[34] Many argue this theory best allows states to act as laboratories of democracy.[35] The theory suggests that the federal gov-

29. *See* MORTON GRODZINS, THE AMERICAN SYSTEM: A NEW VIEW OF GOVERNMENT IN THE UNITED STATES 8 (Transaction Publishers, 1966).

30. *See id.*

31. *See id.*; *see also* Gwen Arnold, *When Cooperative Federalism Isn't: How U.S. Federal Interagency Contradictions Impede Effective Wetland Management*, 45 PUBLIUS 244, 245 (2015) (noting that U.S. federal and state governments often pursue policies within the same sphere).

32. *See* Craig Volden, *Intergovernmental Political Competition in American Federalism*, 49 AM. J. POL. SCI. 327, 328 (2005).

33. *See* Richard A. Musgrave, *Devolution, Grants, and Fiscal Competition*, 11 J. ECON. PERSPECT. 65, 66–67 (1997). Musgrave also discusses the problems with applying this market and product analogy to the structuring of intergovernmental relationships. *See id.*

34. *See* Charles Tiebout, *A Pure Theory of Local Expenditures*, 64 J. POL. ECON. 416, 422 (1956).

35. *See, e.g.*, Robyn Hollander & Haig Patapany, *Morality Policy and Federalism: Innovation, Diffusion, and Limits*, 47 PUBLIUS 1 (2017) (demonstrating that in certain circumstances, devolution of powers from the federal government to the states can increase state's innovation and experimentation); *see also* Virginia Gray, *Innovation in the States: A Diffusion Study*, 67 AM. POL. SCI. REV. 1174, 1174 (1973) (showing that devolution can result in state policy experimentation, with successful policies being later adopted by neighboring states).

ernment should allow lower levels of governments, like states and localities, to experiment with various policy ideas.[36] Both horizontal and vertical levels of government can then learn from successful states and avoid the cost incurred from enacting ineffective policies.[37] States can monitor the failures and successes of these policy experiments, and theoretically, successful policies will spread to neighboring states and then across the country, in —a process often referred to horizontal diffusion.[38] Further, a bottom-up or vertical diffusion can occur with successful policies at the state level being later adopted at the federal level.[39]

An example of vertical diffusion, or bottom-up policy learning, can be seen in the role that Massachusetts policy innovation played in the drafting of the Federal Patient Protection and Affordable Care Act ("ACA").[40] The three-legged-stool on which the ACA rests includes an employer mandate, expanded Medicaid, and subsidies for individuals purchasing insurance; each of these building blocks is patterned after the Massachusetts experiment with healthcare access reform.[41] In 1988, Massachusetts implemented a "pay or play" employer mandate that required employers to provide health insurance to their employees or pay a fine per employee.[42] In 1996 and 1997, Massachusetts expanded its Medicaid program in an effort to provide more universal coverage.[43] In 2006, Massachusetts had its third wave of healthcare access reform, which included offering individuals subsidies for purchasing health insurance and creating health insurance exchanges where individuals could purchase the insurance.[44] Massachusetts' experimentation with

36. *See supra* note 35.

37. *See* J. Mitchell Pickerill & Paul Chen, *Medical Marijuana Policy and the Virtues of Federalism*, 38 PUBLIUS 22, 24–25 (2008) (explaining how federalism can allow costs of policy innovation to be born only by the state innovating).

38. *See* Hollander and Patapany, *supra* note 35, at 14; *see also* Scott Burris et al., *Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility*, 53 LOUIS U. L.J. 1089, 1147 (2008); Craig Volden, *States as Policy Laboratories: Emulating Success in the Children's Health Insurance Program*, 50 AM. J. POL, SCI, 294, 295 (2006) [hereinafter Volden, *Policy Laboratories*].

39. Hollander & Parapany, *supra* note 35 at 1; *see also* Burris et al., *supra* note 38 at 1147; *see generally* Volden, *Policy Laboratories*, *supra* note 38.

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

41. JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 104–20 (Univ. of California Press, 1st ed. 2011).

42. This requirement applied to employers with six or more employees. *See* John E. McDonough et al., *The Third Wave of Massachusetts Health Care Access Reform*, 25 HEALTH AFF. w420, w421 (2006).

43. *See id.*

44. *Id.* at w421–22

these reforms helped convince policymakers and stakeholders alike that the Massachusetts plan provided the best blueprint for national healthcare reform.[45] In sum, at times, the federal government cherry picks from successful state policies when deciding which policies to implement on a national scale.

Aside from allowing states to innovate, competitive federalism permits the state and local government's a degree of autonomy and encourages the development of policies and laws tailored to the needs of their particular populations.[46] Federal block grants, like those historically used to fund SUD treatment and treatment for mental illness, can be used to allow states the opportunities to develop tailored programs administered at the state level.[47] This devolution of federal responsibilities to the states through mechanisms like block grants is also referred to as "fiscal federalism."[48] Proponents of this approach argue that citizens and corporations can vote with their feet and leave their states if they disagree with the types of policies enacted.[49] In actuality, however, there is conflicting evidence over the degree to which voters are actually mobile and able to exercise such forms of protest.[50]

Despite some of its purported benefits, there are concerns with the degree to which competitive federalism actually encourages a "race to the bottom."[51] Scholars like Paul Peterson and Mark Rom argue that competitive federalism can encourage states to develop the least generous welfare policies.[52] If states offer policies that are substantial in comparison to neighboring states, they risk attracting a flood of "needy" residents relocating from less generous states.[53]

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45. MCDONOUGH, *supra* note 41, at 54.

46. *See* Arnold, *supra* note 31, at 245; *see also* Agranoff, *supra* note 22, at 36 (arguing that states should adopt federal programs to meet their own needs and differences).

47. *See* Brian K. Collins & Brian J. Gerber, *Redistributive Policy and Devolution: Is State Administration a Road Block (Grant) to Equitable Access to Federal Funds?*, 16 J. PUB. ADM. RES. THEORY 613, 618 (2006).

48. Musgrave, *supra* note 33, at 66.

49. Tom Miller, *A Regulatory Bypass Operation*, 22 CATO J. 85, 95–96 (2002). *Cf. also* Spencer H. Banzhaf & Randall P. Walsh, *Do People Vote with Their Feet? An Empirical Test of Tiebout*, 98 AM. ECON. REV. 843, 862 (2008) (finding that people do vote with their feet on environmental policy).

50. *See* Christopher Berry, *Piling On: Multilevel Government and the Fiscal Common-Pool*, 52 AM. J. POL. SCI. 802, 803 (2008).

51. *See generally* Kirsten H. Engel, *Is There a "Race," and Is It "To the Bottom?"*, 48 HASTINGS L.J. 271 (1997).

52. *See generally* Paul E. Peterson & Mark C. Rom, WELFARE MAGNETS: A NEW CASE FOR A NATIONAL STANDARD (Brookings Institution Press, 1990).

53. *See* Michael M. O'Hear, *Federalism and Drug Control*, 57 VAND. L. REV., 783, 858–859 (2004) (explaining that states are encouraged to "race to the bottom" with environmental policies and drug policies); *see also* Volden, *Policy Laborato-*

Using this logic, state legislators may be deterred from enacting robust parity protections because they fear that such generous protections could attract an influx of new residents needing SUD or mental health treatment.

Aside from encouraging states to race to the bottom, competitive federalism is not optimal for the development of civil rights policies or other policies designed to protect disadvantaged citizens.[54] And parity is often framed as an issue of civil rights.[55] Competitive federalism encourages disparate policies and does not create a uniform standard unless that standard is eventually adopted by the federal government through vertical diffusion.[56] Cooperative federalism arrangements (reviewed *infra*), where the federal government sets minimum standards and oversees state implementation, have been shown to be the most effective for the protection of such rights.[57] The benefits of minimum federal standards for state policy are many, perhaps the most important of which is stated by Gwen Arnold:

> [W]hen the federal government dictates minimum standards for state policy, interstate businesses can be assured some degree of consistency; damaging interstate competition can be limited; citizens are guaranteed a minimum degree of equity in receipt of legal treatment and public services; and there may be regulatory economies of scale.[58]

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ries, *supra* note 38 (summarizing the arguments made to support the "race to the bottom" theory as applied to welfare benefits).

54. *See generally*, JONATHAN LEVINE, ZONED OUT: REGULATION, MARKETS, AND CHOICES IN TRANSPORTATION AND METROPOLITAN LAND-USE (Routledge, 2006); DOLORES HAYDEN, BUILDING SUBURBIA: GREEN FIELDS AND URBAN GROWTH, 1820–2000 (Knopf Doubleday Pub. Group, 2003); DOUGLAS S. MASSEY, ET AL., AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE AMERICAN UNDERCLASS (Harv. Univ. Press, 1993); Debra A. Reid, *African Americans and Land Loss in Texas: Government Duplicity and Discrimination Based on Race and Class*, 77 AGRIC. HIST 58, 92 (2003).

55. *See generally* Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE UNIV. L. REV. 179 (2013).

56. *See* Lisa L. Miller, *The Invisible Black Victim: How American Federalism Perpetuates Racial Inequality in Criminal Justice*, 44 L. & SOC'Y REV. 805, 807 (2010).

57. While not all scholars agree that the federal government is best equipped to ensure civil rights protections, most agree that it is the majority view. *See, e.g.*, Reid, *supra note* 55, which demonstrates how the federal government provided greater protections for African American farmers than did the Texas government.

58. Arnold, *supra* note 31, at 245.

Finally, the devolution of policy responsibility to the states through the use of mechanisms like block grants can result in great gaps between policy goals and implementation.[59]

Much of what has been covered thus far in this Section describes competitive federalism as competition between horizontal governments, i.e. state vs. state, local vs. local. However, competitive federalism also applies to situations in which state, local, and federal governments (vertical governments) have the authority to enact policies in areas of shared jurisdiction and do so without coordination.[60] This lack of coordination often results in inefficiencies and confusion by citizens over which government is the enforcer.

C. Cooperative Federalism

While competitive federalism may result in some national uniformity over time, cooperative federalism arrangements prioritize a national acceptable baseline through the creation of federal minimum standards.[61] Cooperative federalism offers a theory for structuring intergovernmental relationships in ways that encourage coordination and cooperation between the levels of government, decreasing inefficiencies and confusion.[62] According to federalism scholar Daniel J. Elazar, collaboration between governments within federalism is the cornerstone of our American democracy. This is specifically due the U.S.'s adoption of a federalist theory of government, a dual governmental structure, and the development of certain cooperative programs and administrative mechanisms for collaboration.[63]

The benefits of the cooperative model are many, including efficiency.

One of the notable early contributors to cooperative federalism, Jane Perry Clark describes cooperative federalism in *The Rise of the New Federalism* as

> a means of coordinating the use of federal and state resources, of eliminating the duplications in activity, of cutting down expenses, of accomplishing work which could not otherwise be carried out,

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59. V.O. KEY, JR., THE ADMINISTRATION OF FEDERAL GRANTS TO STATES 228 (1937).

60. *Issues of Federalism*, *supra* note 24, at 11, 32.

61. Engel, *New Cooperative Federalism*, *supra* note 26, at 461.

62. *Issues of Federalism*, *supra* note 24, at 11.

63. For a review of Elazar's primary concepts, see Agranoff, *supra* note 22, at 31–32. Elazar is credited with moving federalism scholarship away from thinking solely in terms of constitutional law and instead focusing on social science approaches to federalism. *Id.* at 36.

> and in general of attempting to make the wheels of government in the federal system of the United States move more smoothly than would be otherwise possible.[64]

Aside from the benefits outlined by Clark, cooperative federalism permits the federal government to enact social policies that benefit the public and have widespread support but which may not be independently adopted by states.[65] For example, in states with powerful insurance lobbies, health insurance reforms like parity may be difficult to enact because of the political costs. Mandatory federal guidelines requiring parity allow state legislators to pass the political blame onto the federal government while continuing to enforce a policy that benefits their constituents.

As a governance structure, cooperative federalism facilitates centralized control but still allows the federal government to devolve certain aspects of implementation to the states.[66] Some state officials report welcoming the help, expertise, and guidance of federal officials, in part because they often share similar career backgrounds and training.[67] Aside from furthering cooperation with federal officials, cooperative federalism encourages states to tailor policies to their local constituents by authorizing partial preemption—where the federal standard operates as a floor, but states are permitted to enact stricter policies.[68] The combination of state and federal law results in dual enforcement of these laws by both federal administrative agencies and state attorneys general.[69] This increases the likelihood that violations of law will be investigated and remedied. Admittedly, this one-tail devolution created by partial preemption tends to favor progressive states more than conservative states, as partial preemption is most likely to be used to provide citizens with greater protections and benefits.[70] However, for the enforcement of parity laws, dual enforcement could help actualize parity, at least in some states. Moreover, partial preemption autho-

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64. JANE PERRY CLARK, THE RISE OF A NEW FEDERALISM: FEDERAL-STATE COOPERATION IN THE UNITED STATES 9 (Russel & Russel eds., 1966)

65. *See* Arnold, *supra* note 31, at 245.

66. *Id.* at 244.

67. Agranoff, *supra* note 22, at 35.

68. *See* Timothy J. Conlan & Paul L. Posner, *American Federalism in an Era of Partisan Polarization: The Intergovernmental Paradox of Obama's "New Nationalism"*, 46 PUBLIUS 281, 294, 298 (2016).

69. *See* Jessica Bulman-Pozen & Gillian E. Metzger, *The President and the States: Patterns of Contestation and Collaboration Under Obama*, 46 PUBLIUS 308, 322–323 (2016).

70. *See* Conlan & Posner, *supra* note 68, at 293–94.

rizes states to experiment with more robust parity policies while still ensuring a federal minimum.

The benefits of a cooperative federalism model seem to outweigh the costs for the implementation and enforcement of policies like parity. There may also be structural realities that would require a cooperative arrangement. Federalism scholar Agranoff argues that the current division of powers between the U.S. federal and state governments has made collaboration between the governments the default. "Collaboration," he writes, "or at least a lack of federal control, exists by default, so to speak, because of the very real limits on the federal (and state) government's ability to control subnational officials' actions."[71] Even if cooperative federalism is the default as Agranoff argues, and a preliminary review of the cooperative federalism research supports cooperation in areas like parity where discrimination or civil rights violations are a concern, the structure of the divisions of powers within the collaborative relationship requires more careful analysis.

1. Division of Powers in Cooperative Arrangements

In determining how to allocate power and responsibilities in cooperative relationships, some cooperative federalism scholars have argued that federal dominance in areas of shared jurisdiction is warranted because, historically, the federal government has been "[o]n the whole more stable, more responsive to public needs, more effective in administration not to speak of its greater concern for civil liberties."[72] While states' capacity to administer public policy has increased,[73] when broad policy goals require concentrated action, federal dominance is preferable,[74] particularly for goods like healthcare or health insurance (which can be seen as national vs. local goods).[75] This suggests that federal dominance in the regulation and implementation of parity laws may be warranted.

Federal dominance appears to be typical of current cooperative governmental relationships, with the federal government in charge of the decision-making and states expected to implement

71. Agranoff, *supra* note 22, at 52.

72. *Id.* at 41 (citing RICHARD ROSE, UNDERSTANDING BIG GOVERNMENT 4 (1984); *see also Issues of Federalism*, *supra* note 24, at 12. *See generally* Reid, *supra* note 54 (outlining a policy instance in which federal action was needed in order to ensure equity for sharecroppers in Texas).

73. *See* Robert Jay Dilger, *The Study of American Federalism at the Turn of the Century*, 32 ST. & LOC. GOV'T REV. 98, 102 (2000).

74. Agranoff, *supra* note 22, at 41.

75. *Cf.* Musgrave, *supra* note 33, at 67.

federal guidelines.[76] Professor Michael Doonan likened the relationships between the federal and state governments in contemporary cooperative arrangements to that of a junior and senior partner in a law firm.[77] While the relationship is technically a partnership, the junior partner is often expected to carry out the wishes of the senior partner and is not on equal footing when it comes to decision-making.[78] Doonan argues that federal involvement in healthcare policy has been largely patterned on this junior/senior partnership model.[79] Extending his theory, I will demonstrate *infra* how the junior/senior partnership model adequately describes intergovernmental relationships in implementing and enforcing parity.

Doonan maintains that states should be employed as more equal partners in the planning and designing of the implementation process than is currently the norm in cooperative arrangements. However, as greater state involvement increases, so does the likelihood that states will try to subvert the protections of national regulations, particularly if the federal policy was passed along partisan lines. For example, when states were tasked with implementing sections of the ACA, state level administrators intentionally used their power of discretion to shift policies back towards the state level political majority—even when doing so undermined the protections of the ACA.[80] As was also demonstrated by state administration of components of the ACA, state administrators can refuse to bargain over the implementation of critical parts of the federal law.[81]

In sum, current research in cooperative federalism, particularly as applied to healthcare policy, suggests that the federal government may need the states' assistance in implementing and enforcing federal policies due to issues of capacity and the structure of Amer-

76. *See generally* Michael Doonan, American federalism in practice: The Formulation and Implementation of Contemporary Health Policy (Brookings Inst. Press, 2013). *See also* Agranoff, *supra* note 22, at 32. It is important to note that there has been much scholarship devoted to the idea that the amount of federal government involvement has shrunk, particularly during and after the Reagan presidency. *See Issues of Federalism*, *supra* note 24, at 16–17. This was referred to as the "devolution revolution." However, the so-called "devolution revolution" has been convincingly challenged by the concept of "new federalism," which suggests that federal government involvement in social policies has not decreased but rather changed in character. Federal dominance in a guideline setting has remained, but the federal government has devolved the implementation of programs and enforcement of federal regulations to states to a greater degree. *See* Cho & Wright, *supra* note 63, at 58; *see also* Dilger, *supra* note 73, at 102.

77. Doonan, *supra* note 76, at 11.

78. *Id*.

79. *Id*. at 25.

80. Rocco, *supra* note 19, at 418.

81. *Id.*

ican federalism. Based on an analysis of healthcare policies, Professor Doonan concludes that federal dominance in decision-making is typical in cooperative arrangements. While cooperative federalism relationships may be desired and necessary, issues with state buy-in and willingness to actively implement and enforce federal policies remain. These same issues have indeed surfaced in the implementation and enforcement of federal parity laws. So, how can the federal government make state cooperation more likely given these circumstances?

2. Incentivizing States to Cooperate

If states do not agree to enforce federal policies based solely on the shared belief in the importance of the underlying policy, the federal government can rely on carrots (incentives) or sticks (regulatory penalties) to ensure the implementation and enforcement of federal law.[82]

The use of carrots, or financial incentives, has been historically popular in encouraging the states to collaborate on matters of healthcare policy. Penalties for failure to properly implement or enforce federal healthcare policy have often resulted in the curtailing of previously awarded federal grants-in-aid.[83] However, the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*[84] has placed limits on the extent to which the federal government can place restrictions on previously awarded federal grants to incentivize new behavior.[85] Nevertheless, carefully tailored financial incentives and penalties can and should be components of any cooperative arrangements to enforce federal parity laws. Such financial incentives and penalties must be accompanied by active federal oversight of states' enforcement of federal parity laws.

To illustrate the importance of active federal oversight in conjunction with carrots and sticks, consider two health policy exam-

82. Arnold, *supra* note 31, at 245.

83. Cho & Wright, *supra* note 63, at 2, 4 (citing examples of such coercion including crosscutting requirements, crossover sanctions, and preemption).

84. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) [hereinafter *NFIB v. Sebelius*].

85. *Id.* The Court opined that "the threatened loss of funding is so large that States have no real choice but to participate in the Medicaid expansion" and that the federal government could not attach the penalties to the existing Medicaid program funding because the Medicaid expansion was akin to an entirely new program altogether and not a mere addition. *Id.* at 625. In ruling this, the Court stated that "when . . . conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes." *Id.* at 580.

ples of cooperative arrangements where the federal government tried to elicit state cooperation in administering federal programs and enforcing federal law. In the first example, the federal government provided the states with substantial financial incentives, penalties tied to these incentives, and active program oversight ("Example 1"). In the second example, the federal government provided minimal federal resources and nominal state oversight ("Example 2").[86] Both of these examples provide useful comparisons to the current structure of federal parity implementation.

Admittedly, refusal of states to adopt the Medicaid expansion under the ACA calls into question the effectiveness of financial incentives amidst contemporary partisan politics. I will address the practicalities of incentives and regulatory penalties post-ACA in Section 3(c) and ask the readers to hold such objections in abeyance until then.

a. Example 1: CHIP

In 1997, the federal government created the Children's Health Insurance Program ("CHIP"), a program that provides health insurance benefits to children from families whose incomes are too high to qualify for Medicaid.[87] States administer the program according to federal guidelines, and the federal and state governments jointly fund the program.[88] Federal grant funding for the program is generous, ranging from 65 to 85 percent of total program costs, depending on the states per capita income levels.[89] All states have opted to participate in the program with most states expanding the maximum federal income limits for eligibility to up to 200 percent of the federal poverty limit.[90] States were given great autonomy in program design and many states took the opportunity to experiment;[91] however, federal guidelines required federal approval for

86. DOONAN, *supra* note 76, at 5, 13.

87. Centers for Medicare & Medicaid Services, U.S. Dep't of Health & Human Servs., *Program History*, MEDICAID.GOV, https://bit.ly/328nXuG [https://perma.cc/UGN9-QZKZ] (last visited Feb. 22, 2020).

88. Centers for Medicare & Medicaid Services, U.S. Dep't of Health & Human Servs., *Children's Health Insurance Program*, MEDICAID.GOV, https://bit.ly/3bQTBkX [https://perma.cc/PQF6-9JAT] (last visited Feb. 22, 2020).

89. *See* Volden, *Policy Laboratories*, *supra* note 38, at 296–97 ("All states found the matching grants offered by the federal government through the CHIP program too attractive to pass up.").

90. Centers for Medicare & Medicaid Services, *supra* note 88. Initial eligibility levels adopted by the states ranged from 133 percent to 300 percent of the federal poverty level. *See id.* at 296.

91. *See* Volden, *supra* note 38, at 296–97.

each state amendment or change to the program.[92] Thus, the generous incentives and freedom to innovate were combined with active oversight and reporting requirements. According to Professor Doonan, this winning combination of carrots and sticks contributed to CHIP's relative success.[93]

b. Example 2: HIPAA

The story of HIPAA, the Health Insurance Portability and Accountability Act, is used by some federalism scholars as an example of what can go wrong when intergovernmental relationships are structured poorly.[94] HIPAA was enacted by Congress to provide minimum national benefit standards for health insurance while permitting the states to continue their primary oversight and control over private individual health insurance plans offered to citizens of their state.[95] Although HIPAA is commonly thought of as establishing privacy standards for health information, it contains additional health insurance reforms, including a mandate that some employer-sponsored health plans cover pre-existing conditions.[96] The true potential of HIPAA was not realized, in part, due to states' failures to enforce its provisions—an outcome that was not surprising given the lack of both adequate carrots and sticks to induce state performance.[97] Unlike CHIP, HIPAA provided marginal government resources to enforce the Act, leaving states to pay the costs of enforcement.[98] Perhaps, due in part to the absence of conditional federal grants that could have been used as leverage, HIPAA implementation lacked federal government oversight and reporting requirements;[99] HIPAA's poor enforcement can be linked to this less than optimal structuring of carrots and sticks.

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92. *See id.* at 296–98.

93. DOONAN, *supra* note 76, at 5, 7.

94. *Id.* at 3.

95. *See* Karen Pollitz et al., *Early Experience with "New Federalism" in Health Insurance Regulation*, 19 HEALTH AFF. 7, 8 (2000).

96. *See* CTRS. FOR MEDICARE AND MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996 HELPFUL TIPS 6–7, https://go.cms.gov/2Sx9vJn [https://perma.cc/3ADQ-2ALN] (last visited Feb. 29, 2020).

97. DOONAN, *supra* note 76, at 3.

98. *Id.* at 5.

99. *See id.* at 82. While some may argue that the law also lacked sufficient penalties for states' non-compliance, such penalties are difficult to enact without running afoul of laws that prevent the federal government from mandating the states perform, without providing funding to do so, the so-called "unfunded mandates." *See generally* PAUL L. POSNER, THE POLITICS OF UNFUNDED MANDATES: WHITHER FEDERALISM? (Georgetown Univ. Press, 1998).

3. *Cooperative Federalism in Polarized Times: Challenging the Efficacy of Carrots*

Historically, scholars and policymakers alike often assumed that large financial incentives would induce states to comply with federal wishes. The current political climate has made scholars question these assumptions.

In 2010, the ACA was enacted along partisan lines.[100] This Act required states to expand their Medicaid programs to include persons whose income were below 138 percent of the federal poverty line[101] and to remove categorical restrictions requiring that eligible populations have dependents. The penalties for non-compliance were large and included the loss of funding for existing Medicaid programs—a penalty that the Supreme Court found to be unconstitutional.[102] The Supreme Court concluded, however, that states could choose to expand their Medicaid programs voluntarily under the ACA.[103] Therefore, the federal government had to rely on the generosity of the ACA's incentives to induce the states to act.

Prior to the ACA's enactment, the federal government paid for anywhere from 50 to 77 percent of the state's Medicaid costs.[104] For the newly eligible Medicaid enrollees (the expansion population), the federal government agreed to pay 100 percent of their costs through 2016, 93 percent until 2020, and then 90 percent after 2020.[105] Despite the vast financial incentives, some conservative states opted not to expand Medicaid,[106] arguably choosing ideology over finances.[107] What explains this atypical behavior? Are carrots no longer effective in inducing state cooperation? Is this state behavior evidence that theories of cooperative federalism may no

100. *See* Conlan & Posner, *supra* note 68, at 289.

101. Previously, federal guidelines for Medicaid eligibility only required populations under 100 percent of the federal poverty line be covered. *See* NFIB v. Sebelius, 567 U.S. 519, 627 (2012).

102. *Id.* at 587–88.

103. *Sebelius*, 567 U.S. at 587–88.

104. Robin Rudowitz et al., *Medicaid Financing: The Basics*, KFF (Mar. 21, 2019), https://bit.ly/3baUFyD [https://perma.cc/TUE9-2HET].

105. Susan L. Hayes, et al., *The Fiscal Case for Medicaid Expansion*, THE COMMONWEALTH FUND (Feb. 15, 2019), https://bit.ly/2yyAltC [https://perma.cc/JAK7-FYGC]. While some may argue that poorer states may not have the funds to cover the ten percent of cost-sharing required, states with particularly limited budgets have been able to expand Medicaid by cost-shifting from other state funded programs or increasing state taxes. *Id.*

106. In 2019, 14 states have not expanded Medicaid. *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (Jan. 2, 2020), https://bit.ly/2WaTg6A [https://perma.cc/2978-73E8].

107. *See* Conlan & Posner, *supra* note 68, at 289–90.

longer be useful in explaining current trends in intergovernmental relationships?

Contemporary partisan politics must be accounted for in order to more accurately predict state cooperation in the administration of federal programs. Ideological considerations appear to moderate the influence of financial incentives on state behavior.[108] Moreover, cooperation between the levels of government can seem even less likely due to the increase in hyper-partisan governors and differing agendas and priorities between federal, state, and local governments.[109]

Rather than abandon theories of cooperative federalism, scholars have addressed partisanship politics by arguing that states are still cooperating with the federal government but are doing so at variable speeds.[110] Federalism scholars Conlan and Posner have discovered that states are implementing federal polices "[a]t different rates and in different ways in different states[,]" a phenomenon that they call "variable speed federalism."[111] A form of differentiated federalism, variable speed federalism claims that state behavior is motivated by ideological conflicts between political parties that control the three levels of government.[112] This theory also accounts for geographic variations in politics and priorities, even as applied to Medicaid expansion uptake.[113] To reach these findings, Conlan and Posner analyzed interviews with state actors responsible for Medicaid implementation. These interviews supported variable speed federalism's accuracy in describing state behavior during Medicaid expansion.[114]

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108. Philip Rocco et al., *Politics at the Cutting Edge: Intergovernmental Policy Innovation in the Affordable Care Act*, 48 PUBLIUS 425, 429 (2018).

109. *See* Conlan & Posner, *supra* note 68, at 301.

110. *See id*. at 299.

111. *Id*. The authors suggest that "variable geometry" can also be used to describe the current state of federalism in the United States. *See id.* Variable geometry has been used to describe intergovernmental relationships in the European Union, where differences between states become institutionalized. *See id.* However, studying the institutionalization of variable state implementation of federal law is beyond the scope of this Article.

112. *See id.* at 300.

113. *Id*. at 281.

114. *Id*. at 289. According to Matt Salo, executive director of the National Association of Medicaid Directors, "[t]here is movement in every state. They'll get there. Maybe not today and maybe not this year, but they'll get there soon." According to health policy expert Len Nichols, "[t]his is a large and diverse country, and the people of the different states have different priorities and even values. . . . But math eventually trumps ideology, though at different speeds for different people." *Id.*

In sum, theories of federalism offer varying perspectives on how intergovernmental responsibilities should be (or are being) structured to facilitate successful implementation and enforcement of policies in ways that account for the American system of federalism. Given the research presented in this Section, cooperative federalism appears to best describe current federal-state relations. However, as the comparison of the implementation of CHIP and HIPPA demonstrate, not all cooperative federalism arrangements are equally as effective. To ensure adequate state cooperation in implementing federal policies, federal policies calling for state enforcement must be accompanied by financial incentives, clear federal standards, federal oversight, and reporting requirements. Finally, federal expectations of state cooperation must address the likelihood that states will vary in the speed and approach taken to implement these federal policies.

In the following Section, I analyze federal-state relations in health insurance regulation in the United States and in doing so, apply the theories of federalism reviewed above. I begin by examining the statutory divisions of powers to regulate insurance, highlighting implications for federalism and providing the context within which parity was born.

III. FEDERALISM, HEALTH INSURANCE AND PARITY

A. The Marble (and Layer?) Cake of Health Insurance Regulation

Throughout modern history, there has been a battle between the federal government and the states over the regulation of health insurance. These conflicts have created what I call "federalism friction," or disagreements over how powers and responsibilities should be divided between the federal and state governments. These disagreements can be long-lasting and are often not easily forgotten by the parties involved. Federalism friction has become a common byproduct of health insurance regulation in the United States and has only worsened as the federal government has expanded its role in regulating the markets within which groups and individuals purchase health insurance.[115] To better understand how and why federal parity policy implementation has been affected by issues of federalism, a brief contextual overview of issues of federalism that have arisen in health insurance regulation is warranted.

115. *See* Frank & McGuire, *supra* note 6, at 127–28.

Historically, private health insurance was regulated by the states.[116] In 1869, the U.S. Supreme Court ruled in *Paul v. Virginia*[117] that the issuance of an insurance policy was a contractual relationship and not a transaction of commerce.[118] In doing so, the Court reinforced the states' power to regulate insurance and prohibited federal regulation under the Commerce Clause, Article I, Section 8, Clause 3, of the U.S. Constitution.[119] In 1914, the U.S. Supreme Court again acknowledged the states' power to regulate insurance by holding that the regulation of insurance fell under the states' police powers.[120] For nearly 75 years, states enjoyed almost exclusive jurisdiction over health insurance, among other general liability insurance.[121] However, in 1944, confronted with the reality that insurance transactions increasingly involved the negotiation and execution of insurance contracts across state lines, the Supreme Court overruled *Paul* in *United States v. South-Eastern Underwriters Association*.[122] The Supreme Court held that the sale and issuance of insurance contracts are acts of commerce.[123] Justice Black wrote:

> Ordinarily courts do not construe words used in the Constitution so as to give them a meaning more narrow than one which they had in the common parlance of the times in which the Constitution was written. To hold that the word 'commerce,' as used in the Commerce Clause, does not include a business such as insurance would do just that.[124]

After *South Eastern Underwriters*, states could no longer maintain their exclusive jurisdiction over insurance regulation. Insurers feared strict federal regulations. So, states and insurers lobbied for federal legislation that would limit federal encroachment on this traditional state power.[125] Congress responded with the 1945 Mc-

116. Kala Ladenheim, *Health Insurance in Transition: The Health Insurance Portability and Accountability Act of 1996*, 27 PUBLIUS 33, 34 (1997). It was not until the 1930s that the states began regularly exercising their powers to regulate private health insurance. *See Issues of Federalism*, *supra* note 24, at 17–18.

117. Paul v. Va, 75 U.S. 168 (1969).

118. *See id.* at 183.

119. U.S. CONST. art. I, § 8.

120. *See* German All. Ins. v. Lewis, 233 U.S. 389, 407–09, 413–14 (1914).

121. *See* United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533, 534 (1944).

122. *Id.*

123. *See id.* at 553.

124. *Id.* at 539.

125. *See* Nicole Huberfield, *Federal-State Tensions in Fulfilling the ACA's Promises*, NAT'L CONST. CTR. (Oct. 7, 2013), https://bit.ly/2tUERjM [https://perma.cc/23QE-XY5Q].

Carran-Ferguson Act,[126] which stated that if a federal statute—not enacted specifically to regulate the business of insurance—indirectly regulated insurance in a way that conflicted with state law, the state laws governing insurance would supersede the federal law.[127] While this Act reinforced state power to regulate insurance, it also made clear that when Congress chose to regulate insurance, federal law would preempt state law.[128]

It was not until the creation of Medicare and Medicaid in the 1960s that the federal role in health insurance expanded, thereby setting the stage for greater federal involvement in the regulation of health insurance.[129] In 1974, Congress enacted Employee Retirement Income Security Act ("ERISA"). While ERISA was passed primarily to address the rise of bankrupt pension plans, it also greatly restricted the ability of states to regulate private-sector employer and union health benefits (ERISA plans).[130] ERISA created exclusive federal jurisdiction over self-funded (or self-insured) employer-provided health benefit plans by defining them as benefit plans and not insurance.[131] Employers fully funded these plans, receiving premium payments from the employee and then paying the costs of their medical claims.[132] Under ERISA, states maintained the power to regulate insurance carriers and health maintenance organizations (HMOs) but were preempted from regulating self-funded employee-benefit plans (self-insured plans).[133] This meant that self-insured plans did not have to provide benefits mandated by the state, only those mandated by the federal government.[134]

ERISA not only regulated self-insured plans but also created federal minimum standards for all employer-sponsored health plans, including those where the employer purchased health insurance for the employee from private insurers at a group rate.[135] ER-

126. Act of Mar. 9, 1945, ch. 20, 49 Stat. 33 (codified at 15 U.S.C. §§ 1011–15).

127. *See* 15 U.S.C. § 1012(b).

128. *See id.*

129. *Issues of Federalism*, *supra* note 24, at 20.

130. *ERISA*, U.S. DEP'T OF LABOR, https://bit.ly/2OGJjKe [https://perma.cc/W54M-Q4DA] (last visited Feb. 9, 2020).

131. 29 U.S.C. §§ 1144(a), (b)(2)–(3) (2018).

132. *Self-Insured Plan*, U.S. CTRS. FOR MEDICARE AND MEDICAID SERVS., https://bit.ly/37cWXLF [https://perma.cc/U2Q4-S3CL] (last visited Feb. 29, 2020).

133. 29 U.S.C. §§ 1144(a), (b)(2).

134. *ERISA Plans*, KAISER FAMILY FOUND., https://bit.ly/2VnyVcR [https://perma.cc/DZD5-RBET] (last visited Apr. 5, 2020).

135. *ERISA*, U.S. DEP'T OF LABOR, *supra* note 130. ERISA does not apply to group health plans provided by governmental entities or churches.

ISA established a formal grievance process for violations, which is overseen by the federal government.[136]

While ERISA provided a federal minimum for some health-care plans, it also created two layers of oversight and regulation of private health insurance—one overseen exclusively by the federal government and the other primarily by the state governments. In doing so, ERISA increased the level of complexity for future health insurance reform, including that of parity. To truly create a national standard that applied to all health insurance plans, all states and the federal government would now need to adopt the same minimum standards.

ERISA was not without its opponents. Several states tried to regain their exclusive jurisdiction over employer-sponsored health insurance, but neither Congress nor the federal courts heeded their pleas.[137] Moreover, while ERISA may have provided sufficient minimum standards for some employee benefits, the protections it offered were not as robust for health insurance and were often less generous than state laws governing health insurance.[138] State leaders expressed frustration with the ERISA preemption because, rather than creating a federal minimum which states could exceed, it handicapped state actors and prevented them from enacting state-wide benefit mandates that would benefit all of the state's citizens.[139]

ERISA has endured, and through the use of the interstate commerce clause (among other federal powers), the federal government has continued to expand its regulation of private health insurance plans.[140] However, support for health insurance reform has met political opposition from conservative factions and has become embroiled in party politics, resulting in the passage of the ACA along party lines and state refusal to cooperate in its implementation.[141] The policy history of health insurance regulation presented

136. 29 U.S.C. § 1001 (2018). ERISA is administered by the Department of Labor. *See Health Plans and Benefits*, U.S. DEP'T OF LABOR, https://bit.ly/2OHOLMR [https://perma.cc/9R35-DRX8] (last visited Feb. 9, 2020).

137. *See Issues of Federalism*, *supra* note 24, at 22. Employers that operated in more than one state preferred the exclusive federal regulation because it meant they only had to comply with one regulator as opposed to trying to meet the regulations of multiple states. *See id.*

138. *See* Karl Polzer & Patricia A. Butler, *Employee Health Plan Protections Under ERISA*, HEALTH AFF., 93, 94–95 (1997).

139. *See Issues of Federalism*, *supra* note 24, at 22.

140. For a short history of federal expansion into health insurance regulation, see Sparer et al., *supra* note 28, at 37–44.

141. *Divided States of America: Part 1* (PBS television broadcast Jan. 17, 2017) PBS, https://to.pbs.org/39AjvYe [https://perma.cc/5DY3-PVTX] (last visited

in this Section, a history wrought with growing federalism friction, provides context needed to better understand the difficulties faced by parity advocates in designing health insurance reform that would increase access to SUD treatment coverage. The following Section explores the development of parity and how the previous battles over issues of federalism have shaped its implementation and enforcement.

B. Federalism and Parity

As briefly mentioned in the introduction, private health insurance firms have historically refused to cover mental health and SUD treatment benefits.[142] In the past, the primary reasons cited for excluding mental health benefits and SUD benefits were fear of moral hazard and fear of adverse selection.[143] Moral hazard refers to the belief that people will overuse a benefit, like healthcare, if they perceive it to be "free."[144] This theory has been routinely used by health insurers, and some scholars to justify increased cost-shar-

Feb. 17, 2020); *Divided States of America: Part 2* (PBS television broadcast Jan. 18, 2017) PBS, https://to.pbs.org/39AjvYe [https://perma.cc/5DY3-PVTX] (last visited Feb. 17, 2020).

142. *See, e.g.*, DANIA PALANKER ET AL., NAT'L ALL. ON MENTAL ILLNESS, MENTAL HEALTH PARITY AT RISK: DEREGULATING THE INDIVIDUAL MARKET AND THE IMPACT ON MENTAL HEALTH COVERAGE 2 (2018), https://bit.ly/2SDMfcM [https://perma.cc/Y7UN-MESK].

143. Sam Huber, *Parity in Mental Health Coverage: Moral Hazard, Adverse Selection, and the Domenici/Wellstone Act*, VIRTUAL MENTOR (2002), https://bit.ly/2V1w9eC [https://perma.cc/W66C-FJ22]. Presence of a public state system that covered the costs of SUD treatment are also thought to have contributed to the lack of private insurance coverage for SUD treatment. *See* Frank & McGuire, *supra* note 6, at 143.

144. N. Gregory Manikw, *The Economics of Healthcare*, HARV. UNIV.: DEP'T ECON., 1, 5 (Sept. 26, 2017, 3:17 PM), https://bit.ly/2HFvKGM [https://perma.cc/8KKX-QXXT].

ing[145] in an effort to control healthcare spending perceived as unnecessary and wasteful.[146]

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145. For the benefit of readers without a healthcare background, this footnote defines terms commonly used to describe cost-sharing mechanisms in healthcare financing. COST-SHARING refers to the share of out-of-pocket expenses borne by the person insured by the health insurance (the insured). *Cost Sharing*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://bit.ly/2HALLy1 [https://perma.cc/R3ZX-UAC7]. These expenses include deductibles, coinsurance, and copayments but do not include the costs of premiums, costs for using a provider that is not contracted with the insurer (or "out of network"), or the costs of services that are not covered by the health insurance plan. *Id.* PREMIUMS are a set amount paid by the insured typically monthly. *Premium*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://bit.ly/39GKAJk [https://perma.cc/6QHR-WANG]. A DEDUCTIBLE is the amount that the insured must pay before the health insurer begins to cover costs. *Deductible*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://bit.ly/38H1U0A [https://perma.cc/CZ4S-RFBX]. Typically, most insurance health insurance plans cover some services before the deductible is paid, and the ACA requires that these pre-deductible services include specified preventative services. *Id.* If a family is covered under the same health insurance plan, the plan will likely have a family deductible, which is less than the combination of each individual family member's individual deductible. For example, the individual's deductible may be $1,000, but the family deductible may be $1,800. In such a case, the deductible can be met in two ways: when an individual incurs $1,000 in expenses, she has met her deductible; when the total contributed reaches $1,800, the deductible is met for the entire family. Health insurance plans often have separate deductibles for healthcare visits and prescription drug benefits. *Id.* COINSURANCE is the percentage of costs the insured pays after the deductible has been met. *Coinsurance*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://bit.ly/39SUwzh [https://perma.cc/9X57-SED6]. So, for example, if the insured has an $1,000 deductible and 20 percent coinsurance, and the insured is hospitalized for an accident, the insured would pay her $1,000 deductible and 20 percent of the remaining hospital bill. Coinsurance costs are paid after the deductible is met but before the out-of-pocket maximum is reached. *Id.* After the OUT-OF-POCKET MAXIMUM amount has been reached, the insured will no longer be required to pay the coinsurance amount. *Id.* Deductibles can be applied to the out-of-pocket maximum; however, premiums do not count towards the out-of-pocket maximum. *Id.* COPAYMENTS similarly do not apply towards the out-of-pocket maximum and therefore must be paid regardless of whether the out-of-pocket maximum has been met. *Co-payment*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://bit.ly/32cPevT [https://perma.cc/GKN8-5SJ4]. Copayments (or copays) are fixed amounts paid for each service, typically paid at the time of the service. *Id.* The amount often varies depending on the type of service. For example, the copay for a primary care physician may be $20, while the copay for a specialist may be $35. Copayments are paid after the deductible is met or for some services that are permitted before the deductible is met. *Id.* The ACA prohibits insurers from charging copays or other coinsurance for specified preventative visits. *See Preventative Services Covered by Private Health Plans Under the Affordable Care Act*, KAISER FAMILY FOUND. (Aug. 4, 2015), https://bit.ly/38JD4NI [https://perma.cc/5VQA-PHBB]. The amounts the insured is expected to pay in co-insurance costs, as well as out-of-pocket maximums are contractual and differ greatly by plan. *Premium*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., https://bit.ly/39GKAJk [https://perma.cc/6YE3-BVT4].

146. Insured are less likely to utilize services when co-insurance amounts are higher. Robert H. Brook et al., RAND HEALTH, THE HEALTH INSURANCE EXPERI-

Based on this theory, health insurers suspected that covering mental health and SUD benefits would encourage patients to utilize more of these services—even when not medically necessary.[147] Insurers also believed that it would be difficult to objectively determine which mental health and SUD treatments were medically necessary.[148] Unlike most physical illnesses, mental illnesses and SUDs do not have blood tests that can be used to diagnose illness, and the treatments for both mental illness and SUD often vary drastically by provider.[149]

Theories of adverse selection were also used to justify excluding mental health and SUD benefits.[150] "Adverse selection" refers to an increased likelihood that someone with an illness gravitates toward an insurance plan that offers benefits for that illness.[151] For an insurance plan to be sustainable, the plan's risk of "loss" must be

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MENT 1, https://bit.ly/2SPmrcR [https://perma.cc/HQS8-MJZS] (last visited Feb. 22, 2020) [hereinafter THE HEALTH INSURANCE EXPERIMENT]. The threat of moral hazard and the need for cost-sharing was popularized by the findings of this study, which has continued to have significant influence on health insurance scholarship and policy. *Id.* Therefore, plans with higher co-insurance amounts are often cheaper for insurers to administer, not only because the insured is paying a greater percentage of the costs of healthcare, but also because the insured uses less healthcare to begin with. *Id.* As a result, health insurance plans with higher co-insurance amounts tend to have lower monthly premium costs. *Coinsurance*, U.S. CTRS. FOR MEDICARE AND MEDICAID SERVS., https://bit.ly/3bGgcjW [https://perma.cc/A3BB-4K2Q]. While such plans may be good for everyone's pocketbook at the outset, such decreased use may affect the overall health of the insured, particularly if insured has a low income and poor health. THE HEALTH INSURANCE EXPERIMENT at 3.

147. *Dr. Arons Testifies for Inclusion of Mental and Addictive Disorders Benefits*, *in* SAMHSA NEWS 9–10 (Office of Commc'ns, 1993).

148. Graison Dangor, *Mental Health Parity is Still an Elusive Goal in U.S. Insurance Coverage*, NPR (June 7, 2009, 5:00 AM), https://n.pr/2SQPTiF [https://perma.cc/CXD7-SD99].

149. SARA ROSENBAUM ET AL., MEDICAL NECESSITY IN PRIVATE HEALTH PLANS: IMPLICATIONS FOR BEHAVIORAL HEALTH CARE, DEP'T OF HEALTH AND HUM. SERVS. 14 (2003), https://bit.ly/37tIB9L [https://perma.cc/6JPS-ALQC] ("The nature of behavioral health care services compared to general physical medical care is such that there is less 'objective' evidence available to guide decisions that reflect a consensus as to what the appropriate treatments should be for a given diagnosis."). For an explanation of how this issue, in turn, impacts the ability for those seeking mental health services to be approved for needing treatment, see NAT'L ALL. ON MENTAL ILLNESS, A LONG ROAD AHEAD: ACHIEVING TRUE PARITY IN MENTAL HEALTH AND SUBSTANCE USE CARE 4–5 (2015), https://bit.ly/38xBOgt [https://perma.cc/QYE2-2VGB].

150. *See* Richard G. Frank et. al., *Solutions to Adverse Selection in Behavioral Health Care*, HEALTHCARE FIN. REV., 109, 109 (1997).

151. *See* Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity,* 88 THE MILBANK Q., 404, 412 (2010).

spread across a large and diverse population, where the healthy can subsidize the sick; adverse selection threatens this balance.[152]

While theories of adverse selection and moral hazard have made private insurers weary of covering SUD treatment benefits, public payers, including Medicaid and Medicare, have historically covered mental health and SUD benefits—with Medicaid currently funding 50 to 70 percent of all mental health and SUD benefits.[153] State and local governments have also borne a large responsibility for the funding of community mental health centers and local psychiatric hospitals.[154] And this financial responsibility has, at times, motivated some state legislatures to enact parity legislation to help offset state costs.

C. Parity & Its Federalism Implications

The first public conversation about parity occurred in 1961 when President John F. Kennedy ordered "[t]he Civil Service Commission to offer equal insurance coverage for mental health and 'general medical care.'"[155] Eight Congresses later, mental health parity legislation was introduced but did not pass.[156] Building on the policy ideas presented by the Kennedy administration, state legislatures in the 1970s and 1980s began enacting mandated benefit laws that required insurers to provide a minimum level of benefits for alcoholism (38 states), other SUDs (25 states), and mental health (18 states).[157] Mandated benefit laws helped defeat the fears

152. *See id.*

153. Katharine R. Levit et al., *Future Funding for Mental Health and Substance Use Disorder: Increasing Burdens for the Public Sector*, 27 HEALTH AFF. 513, 513 (2008). Since Medicaid's founding in 1965, "[m]edicaid rapidly began to dominate mental health spending." Richard G. Frank & Sherry Glied, *Changes in Mental Health Financing Since 1971: Implications for Policymakers and Patients,* 25 HEALTH AFF. 601, 604 (2006). Medicaid and CHIP are currently responsible for 50 to 70 percent of all MHSA expenditures, depending on the state. *The Federal and State Role in Mental Health*, MENTAL HEALTH AM., https://bit.ly/2Ssqcpo [https://perma.cc/23EX-L3R8] (last visited Feb. 22, 2020).

154. MENTAL HEALTH AM., supra note 155. Although states receive Mental Health Block Grants from the federal government in addition to the funding received from Medicaid and CHIP, states ultimately have the power to determine how to fund their state's mental health services. Id. Furthermore, this state funding is often disseminated further to the counties where services are typically offered on a local level. Id.

155. EXEC. OFFICE OF THE PRESIDENT OF THE UNITED STATES, THE MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY TASK FORCE: FINAL REPORT 3 (2016), https://bit.ly/2W8Z2FP [https://perma.cc/WJC6-NNAR] [hereinafter PARITY TASK FORCE REPORT].

156. *Id.* This initial parity legislation addressed coverage for mental health care, not SUDs. *Id.*

157. Barry et al., *supra* note 151, at 408.

of adverse selection because, if all insurance offered SUD benefits, insurers would not need to worry about persons affected by SUDs being attracted to the plans with SUD benefits. Notably, Connecticut was the first state to implement a "mandated mental health parity law" in 1971.[158] Despite these early efforts, most state legislation did not address parity.[159]

In the 1990s, the parity narrative re-entered the federal discourse when "[c]onsumer advocates pressing for benefit parity at the state and federal levels began framing the issue more explicitly as an antidiscrimination measure."[160] The efforts were rewarded with the enactment of the Mental Health Parity Act of 1996 ("MHPA").[161]

While advocates had hoped for a comprehensive parity bill, in order to get the necessary votes for enactment, the proposed version of MHPA only applied to large employer health plans (with 50 or more employees) and included a cost exemption.[162] Moreover, MHPA only required mental health benefits have the same annual and lifetime dollar limits as physical health benefits but did not address other treatment limits,[163] ultimately making the mental health benefits "[l]ess generous than coverage for other health benefits."[164] MHPA's protections also did not apply to SUD benefits.[165] Because of these deficiencies, many advocates viewed MHPA as primarily a symbolic victory;[166] others viewed it as the first step in incremental policy change.[167]

The next incremental step in achieving parity occurred in 1999 when the Clinton administration required mental health and SUD

158. Lucas Quass, *Federal Efforts to Achieve Mental Health Parity: A Step in the Right Direction, But Discrimination Remains*, 4 LEGIS. & POL'Y BRIEF 35, 49 (2012).

159. *Id.*

160. Barry et al., *supra* note 151, at 409.

161. Mental Health Parity Act of 1996, Pub. L. 104-204, § 701,110 Stat. 2944 (1996).

162. Barry et al., *supra* note 151, at 407. If an employer could demonstrate that costs increased by more than two percent during the first year of implementation and one percent every subsequent year, then they would be exempt from complying with MHPA. *Id.*; *see also The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CTRS. FOR MEDICARE AND MEDICAID SERVS., go.cms.gov/2Sr8qmC [https://perma.cc/77EB-HWW7] (last updated Oct. 27, 2016) [hereinafter CMS, *MHPAEA Fact Sheet*].

163. Barry et al., *supra* note 151, at 407.

164. Sarah Goodell, *Health Policy Brief: Enforcing Mental Health Parity*, HEALTH AFF. 1, 2 (2015), https://bit.ly/39bP2Qt [https://perma.cc/U5NR-4HAH].

165. Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL'Y 455, 479 (2011).

166. Barry et al., *supra* note 151, at 410.

167. *See id.* at 416.

treatment parity for the federal employees health benefit program.[168] This was a critical point in parity history because it gave researchers a natural policy experiment with federally collected data on the actual costs and benefits of mental health parity. The analysis on this data resulted in findings that would help quiet concerns about moral hazard.[169] Although it took another nine years after President Clinton's directive before federal parity would see another expansion, "top-down" policy diffusion[170] occurred—37 state legislatures passed state parity bills between 1996 and 2006.[171] These state parity laws varied in their protections, with some limiting their protections to public employees[172] and others providing comprehensive state parity laws requiring parity across both qualitative and quantitative treatment limits.[173] While some victories were won at the state level, the disparities between the state regulations lead advocates to again ask the federal government to intercede.

In 2008, federal policymakers expanded federal parity law with the passage of the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), which amended ERISA.[174] The MHPAEA not only added SUD benefits, but it also required parity for all financial requirements and treatment limits, including out-of-network coverage.[175] It prohibited separate cost sharing and treatment limits.[176] Although the MHPAEA extended parity requirements and added SUD benefits, it did not include a benefit mandate—a mandate which would have required all large group plans to provide mental health and SUD benefits.[177] MHPAEA only required that, if a health plan included mental health and SUD benefits,

168. *See* Goodell, *supra* note 164, at 2 (addressing cost sharing treatment limits, and number of visits).

169. *Id*.

170. *See* Lucie Cerna, ORG. FOR ECON. CO-OPERATION & DEV., THE NATURE OF POLICY CHANGE AND IMPLEMENTATION: A REVIEW OF DIFFERENT THEORETICAL APPROACHES 11 (2013), bit.ly/2OYiod4 [https://perma.cc/84CR-5W7A] ("Top-down processes mean that policy decisions from the national level are passed on to lower levels. . . .").

171. Barry et al., *supra* note 151, at 410.

172. *Id.* (explaining how South Carolina's law only applied to public employees).

173. *Id.*

174. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511–12, 122 Stat. 3765, 3881–93 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)); 45 C.F.R. §§ 146, 147 (2013); *see also* CMS, *MHPAEA* Fact Sheet, *supra* note 162.

175. CMS, *MHPAEA Fact Sheet*, *supra* note 162.

176. *Id.*

177. *See* Goodell, *supra* note 164, at 2.

those benefits must be at parity with physical health benefits.[178] As such, rather than take on the additional cost that parity was predicted to create, insurers could simply refuse to offer mental health and SUD benefits altogether.[179] While the lack of a benefit mandate greatly weakened MHPAEA, its inclusion would have resulted in increased lobbying efforts against the bill from the business lobby, which was already weary of the increased costs that parity could bring.[180]

Policy entrepreneurs decided to continue with their strategy of incremental policy change, sensing the opportunity for further parity reform would soon present itself.[181] Their patience was rewarded in 2010 with perhaps the greatest expansion of federal regulation of health insurance, the ACA.[182] Among other provisions, the ACA had a benefit mandate that required all ACA-compliant individual and small group market health insurance plans (qualified health plans) to provide ten essential health benefits ("EHB"s).[183] Parity advocates negotiated the inclusion of mental health and SUD benefits as one of these ten EHBs.[184] However, this benefit mandate only applied to individual and small group

178. Megan Douglas et al., *Morehouse School of Medicine, Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report*, PROVIDENCE ST. JOSEPH HEALTH 1, 1 (2018), https://bit.ly/3dmHzQ3 [https://perma.cc/89H7-98VY] (explaining how insurers must "treat illnesses of the brain, such as depression or [SUDs], the same way they treat illnesses of the body, such as diabetes or cancer").

179. *The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Jan. 29, 2010), https://go.cms.gov/3cn5CP4 [https://perma.cc/7XGJ-WLYC] ("The MHPAEA regulation updates the small employer exemption [and] withdraws the MHPA regulations concerning the increased cost exemption."). Further, the MHPAEA lacked other important requirements, including the requirement that specific disorders will be covered, while also allowing for an exception to the law for one year if a plan's cost increases by one percent or more due to parity. *See* Goodell, *supra* note 164, at 3.

180. *See* Barry et al., *supra* note 151, at 417 ("In the Senate, it had become increasingly clear to Senators Domenici and Kennedy that the only viable approach to gaining passage would be to draft a bill that both parity advocates and long-time industry opponents could support.").

181. *Id*. at 418 ("Anticipating the likelihood of health care reform in the event of a Democratic presidential victory, industry groups also were motivated to come to a resolution on parity before the 2008 election. They reasoned that it would be more difficult to influence the shape of parity legislation if it were incorporated into the larger, more unpredictable health care reform debate.").

182. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1, 124 Stat. 119, 119 (2010) ("Quality, affordable healthcare for all Americans.").

183. *State Insurance Mandates and the ACA Essential Benefits Provisions,* NAT'L CONF. OF STATE LEGIS. (Apr. 12, 2018), https://bit.ly/2SD23fO [https://perma.cc/75DP-Z2M9].

184. *See generally* DAWES, *supra* note 181.

health plans sold in the ACA marketplace[185] and did not apply to ERISA plans.[186]

Advocates were also able to amend MHPAEA to extend its parity requirements from covering ERISA plans to also covering all ACA qualified plans.[187] Because of ACA reforms, federal parity laws covered an additional 48 million people.[188]

Through the rule-making process, the Obama administration was able to extend federal parity law protections, so that they protected a total of 126 million people.[189] In 2016, HHS published a final rule that applied parity to CHIP, Medicaid Alternative Benefit Plans, and Medicaid Managed Care.[190] These rules fell short of requiring all Medicaid plans to provide mental health and SUD benefits at parity with physical health benefits, nor did it address the Institute of Mental Disease ("IMD") exclusion.[191] Further, the MHPAEA did not apply to Medicare—public health insurance that provided coverage for approximately 60 million people in 2018.[192] In sum, the number of health insurance plans that were subject to federal parity requirements increased greatly with the enactment of the ACA. Yet, reform fell short of achieving universal parity requirements across all public and private healthcare plans.

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185. Goodell, *supra* note 164, at 2; ERIC GOPLERUD, U.S. DEP'T OF HEALTH & HUM. SERVS., CONSISTENCY OF LARGE EMPLOYER AND GROUP HEALTH PLAN BENEFITS WITH REQUIREMENTS OF THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 3 (2013), https://bit.ly/2WtMnwi [https://perma.cc/NBM8-W5BR] ("[T]he MHPAEA compliance will be a required feature of all health insurance plans sold in the individual and small group markets starting in 2014. . . . [Additionally,] health plans sold in state health insurance exchanges will be required to comply with federal parity requirements.").

186. *See Essential Health Benefits Fact Sheet*, CIGNA CORP. 1 (2018), https://bit.ly/2SDMnb8 [https://perma.cc/8FA7-4CVD].

187. *See id.* at 4.

188. PARITY TASK FORCE REPORT, *supra* note 155, at 4.

189. *See id.* at 3.

190. *Id.* at 4.

191. *See Medicaid Emergency Psychiatric Demonstration Frequently Asked Questions*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Jan. 7, 2020), https://bit.ly/2tYMKEY [https://perma.cc/NNS7-JXSY] (indicating that the IMD exclusion prohibits Medicaid from paying for services provided by IMDs to beneficiaries ages 21 to 64). The IMD exclusion was relaxed in 2018 by the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities ("SUPPORT") Act, which allowed states the option to use Medicaid funds to pay IMDs for up to 30 days. SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 5052, 132 Stat. 3894, 3972 (2018).

192. KAISER FAM. FOUND., AN OVERVIEW OF MEDICARE 1 (2019), https://bit.ly/2OS3vch [https://perma.cc/6FSS-U8XR]. Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA"), Pub. L. No. 110-275, 122 Stat. 2494 is a separate act that does require that copayments cannot be higher for mental health and SUD treatment than for physical benefits. *Id.* § 102, 122 Stat. 2498.

Moreover, the parity victories were accompanied by the political baggage of the ACA. To many Republican legislators, the ACA became a symbol of the Democratic Party establishment, and as such, they attacked the ACA with fervor and zeal.[193] Republican members of Congress called for the ACA's repeal, as Republican governors publicly fought ACA implementation. And, this federalism friction affected how the Obama administration chose to structure the implementation of the federal benefit mandate and federal parity laws.[194]

Prior to the ACA, the Department of Labor and the Treasury Department were responsible for ensuring that ERISA health benefit plans complied with MHPAEA, and CMS was responsible for ensuring that non-federal governmental health benefit plans complied with MHPAEA.[195] After the ACA's enactment, the Secretary of HHS was tasked with determining which SUD benefits would be required by the benefit mandate and which agencies would be charged with enforcing the requirements.[196] Due in part to competing priorities and short implementation timeline,[197] HHS decided, upon the recommendation of the Institute of Medicine, that states should "[m]aintain their traditional role in defining the scope of insurance benefits"[198] and thereby delegated the responsibility of defining the EHB packages, which included the mental health and SUD mandated benefits, to the states.[199] Pursuant to the final rule,

193. *See* Huberfield, *supra* note 125.

194. *See* Goodell, *supra* note 164, at 6 ("It remains to be seen whether states and the federal government are able to take on this level of effort. With states and [HHS] still busy with ACA implementation and enforcement activities, it is likely that we will see more cases going to court to enforce patients' rights under the MHPAEA, especially if courts continue to give standing to advocacy or member organizations and grant class-action status.").

195. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 ("MHPAEA") ENFORCEMENT REPORT 1 (2018), https://go.cms.gov/2SSEONL [https://perma.cc/979M-MFC7]. However, firms with ERISA self-funded plans that wish to opt-out of compliance with MHPAEA must submit applications to CMS.

196. 45 C.F.R. §§ 146–147 (2013); *see also* CMS, *MHPAEA Fact Sheet*, *supra* note 162.

197. *See generally* Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689 (2018); Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Feform and Beyond*, 121 YALE L.J. 534 (2011) (giving examples of federalism politics in the implementation of the ACA and competing priorities).

198. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,843 (Feb. 25, 2013) (to be codified at 45 C.F.R. Pts. 147, 155, & 156).

199. *See id.*

these EHB packages would need to comply with federal parity laws.[200]

Advocates had fought long and hard for a federal minimum standard of parity. HHS, with the promulgation of one rule, reintroduced state level variation in the interpretation of the federal standard. Delegation to the states did not end with the definition of EHB packages. HHS also named states as the primary enforcers of federal parity laws for ACA qualified plans.[201] In doing so, it did not allocate financial incentives to encourage state cooperation in enforcement nor did it develop a system of oversight over state enforcement.[202]

HHS expressly cited to federalism and considerations of the division of powers in issuing this ruling.[203] While HHS determined that reviewing EHB plans for compliance would likely cost the states some money, it reasoned that the sums would not be substantial,[204] and if the states refused to "substantially" enforce the standards, then HHS would enforce them.[205] The marble (and layer) cake of MHPAEA enforcement responsibilities that resulted from this decision is depicted in Figure 1.

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200. *See id.* at 12,844 ("For these reasons, we confirm that plans must comply with the parity standards applicable to mental health and SUD benefits set forth in 45 C.F.R. 146.136 in both the individual and the small group markets in order to satisfy the requirement to cover EHB.").

201. *See id.* ("As the party responsible for enforcement of EHB, it is up to each state to set criteria for substitution in its state . . .").

202. *See id.*

203. *See id.* at 12,864 ("[W]e believe that this final rule has federalism implications due to direct effects on the distribution of power and responsibilities among the state and Federal governments relating to determining standards for health insurance coverage that is offered in the individual and small group markets.").

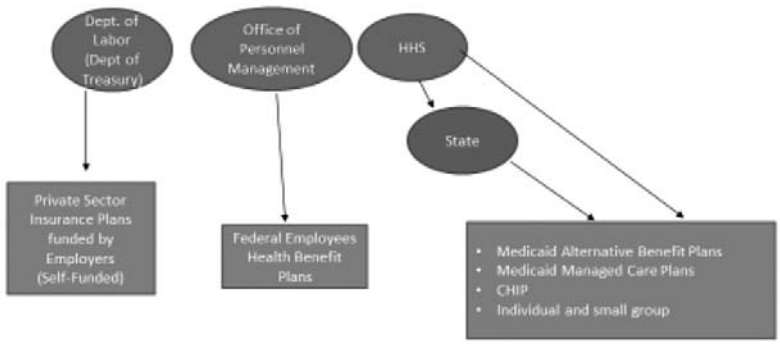
204. *See id.* at 12,844 ("Additionally, because compliance with EHB would require compliance with the parity standards, states would not have to defray any costs associated with bringing plans into compliance because any benefits added to ensure parity would be considered part of the EHB package.").

205. *Id. at* 12,864.

> Each state would adhere to the federal standards outlined in this final rule for purposes of determining whether non[-]grandfathered individual and small group market health insurance coverage includes the EHB package, or have [HHS] enforce these policies. . . . In the view of [the HHS], this final rule does not impose substantial direct costs on state and local governments.

Id.

FIGURE 1.



IV. APPLYING THEORIES OF FEDERALISM TO PARITY ENFORCEMENT

As Figure 1 indicates, the federal parity law enforcement scheme is complex. It demonstrates a form of cooperative governance for some plan types, but one which is segmented and duplicative. This segmentation is compounded by a division of powers over other plan types that is akin to models of dual federalism. The division of responsibilities has been based on plan type and is rooted in federal preemption of state regulation of ERISA plans. It is a product of past legislative decisions, as opposed to a structure or scheme created by design. Complexity and policy history aside, if we were to compare the federal parity law enforcement scheme to the theoretical models presented in Section II, which of those models would it most resemble?

Junior/senior partnership cooperative models best describe the division of powers in healthcare policy in general,[206] but they fall short of describing the parity enforcement scheme because, as applied to parity enforcement, the "juniors" (or the states) have a great degree of autonomy in planning and designing their individual enforcement structures. HHS allowed states to define the EHB benefit plans, designated the states as the primary enforcers of federal parity laws, and granted states complete autonomy in choosing enforcement mechanisms.[207]

206. *See* DOONAN, *supra* note 76, at 11.

207. *See* HHS, Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to

In doing so, HHS structured the division of responsibilities in a way that was similar to Clark's[208] cooperative federalism models (discussed in Section II). HHS even noted that states were best equipped to enforce parity because of their expertise in insurance regulation enforcement.[209] There are some benefits of such an arrangement; theoretically, they allow states to tailor their policy processes to meet the needs of their citizens. They also grant states freedom and decreases friction between the federal and state governments.

The key to success when structuring such cooperative arrangements, however, is to balance state autonomy with incentives and federal oversight. Without federal oversight and financial incentives, federal parity enforcement will likely suffer a fate similar to that of HIPAA and result in wide variation in enforcement, as well as a failure to actualize a national standard.[210] This prediction is further bolstered by models of variable speed federalism. Variable speed federalism supports the argument that states would enforce federal parity laws at varying degrees and in different ways.[211] It also supports the prediction that state governments would try to shape parity enforcement to fit their ideological goals, thereby lessening the prospect of a federal minimum standard for parity.[212] At the writing of this Article, the ACA's federal parity regulations have been in effect for six years—enough time to provide us with data from all 50 states to test these predictions.

V. AN ANALYSIS OF STATE ENFORCEMENT OF FEDERAL PARITY LAWS

After reviewing state legislation, regulations, and administrative guidance, I was able to identify and categorize each states' enforcement scheme—a systematic, empirical process called content analysis. Based on my analysis, I found that states responded to the federal parity laws in three different ways: (1) some states enacted state legislation requiring insurers transacting in the state to follow federal parity laws along with the state parity laws that may have existed, (2) some states did not reference the federal standard but enacted state parity legislation or continued to enforce previously

External Review for Multi-State Plan Program, 78 Fed. Reg. 68,240 (Nov. 13, 2013) (codified at 45 C.F.R. Pts. 146–47) [hereinafter MHPAEA Final Rules]

208. CLARK, *supra* note 64.

209. MHPAEA Final Rules, *supra* note 207.

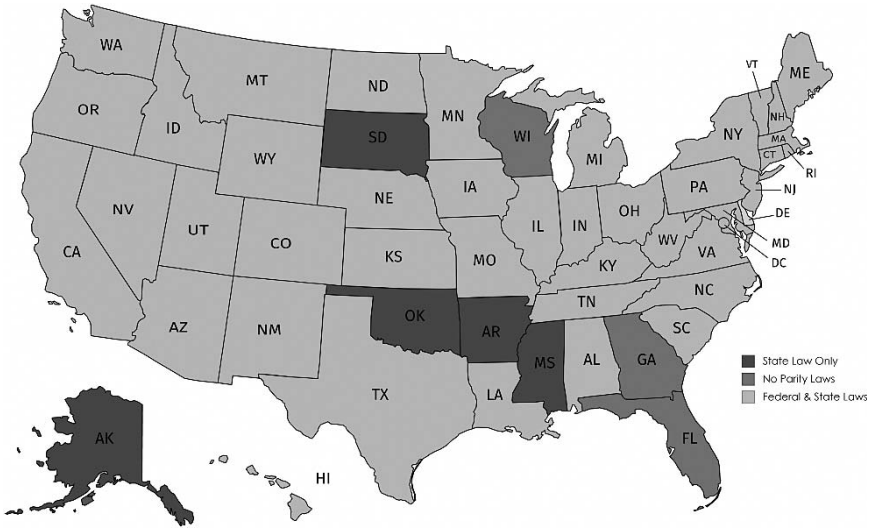
210. *See generally* DOONAN, *supra* note 76.

211. Conlan & Posner, *supra* note 68, at 281, 283, 287, 298.

212. *Id.*

enacted state statutes on parity, and (3) some states explicitly refused to enforce the federal parity laws and did not create a state equivalent. Figure 2 depicts these results, with orange representing states in category (1), purple representing states in category (2), and blue representing states in category (3).

FIGURE 2.



Notably, although the state of Texas initially refused to enforce federal parity laws, in 2017, the state legislature enacted parity legislation that referenced the federal standard.[213] As the theory of variable speed federalism predicted, states varied at the speed in which they engaged in cooperative federalism. My analysis revealed that only three states have still not adopted some form of parity law, and only five states have not incorporated the federal law into state statutes.

Variable speed federalism also predicts that states will vary in the ways in which they choose to enforce federal parity. Unfortunately, it was difficult to capture the mechanisms of enforcement used by the states because most states did not outline the processes they were using to ensure compliance with federal parity laws in their governing documents. After conducting informal phone interviews with employees at a few state insurance commissioners' offices, I confirmed that at least some of these states were relying on the same processes that they had in place to oversee general insur-

213. Act of Sept. 1, 2017, § 1, 2017 Tex. Gen. Laws ch. 769 (codified at TEX. GOV'T CODE ANN. §§ 531.02251, 531.02252 (2019)).

ance compliance. These processes relied on consumers to submit complaints, which would then be investigated.

A few state legislatures and administrative agencies explicitly addressed how they would enforce the federal parity laws in their governing documents. These states varied in the types of enforcement mechanisms used. The results are presented in the following table.

Policy Tool	Description
State Legislative Oversight	Some state legislatures established a parity task force, or committee, which reviewed agency reports of parity enforcement efforts.[214]
Parity Violation Fines	While state causes of action with associated penalties exist for the violation of state insurance laws, some state legislatures created specific monetary penalties, or fines, for insurers who violated parity laws.[215]
Aggressive Investigations	In some states, like California and New York, the state attorney generals' offices have investigated complaints and imposed heavy fines on health insurers that violated parity laws.[216]
Annual Filings	Some state administrative agencies have created self-compliance worksheets and have required the filing of annual forms demonstrating compliance with federal parity laws.[217] These worksheets have also been used to educate insurers on changes in parity policy.
Market Conduct Reviews	In these states, state administrative agencies periodically conducted market reviews, which reviewed health plan coverage and denials of mental health and SUD benefits.[218]

214. *See, e.g.*, 215 ILL. COMP. STAT. 5/370c.2(b) (2019).

215. *See, e.g.*, 40 PA. STAT. §§ 908-14, -15 (2019).

216. New York and California are said to "lead the way" in parity enforcement. Mchael Ollove, *Despite Laws, Mental Health Still Getting Short Shrift*, STATELINE (May 7, 2015), https://bit.ly/3cr68ev [https://perma.cc/PM3L-3RPM].

217. *See, e.g.*, CAL. DEP'T OF MANAGED HEALTH CARE, INSTRUCTIONS FOR THE FEDERAL MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT COMPLIANCE FILING (2014), https://bit.ly/2wAbmFd [https://perma.cc/WZ4R-RHMP].

218. *See, e.g.*, Letter from Al Redmer, Comm'r, Maryland Dep't of Ins. to Sen. Thomas Middleton (June 30, 2017) (on file with author).

Consumer Education	Efforts to educate consumers about their rights under federal parity laws and how to file complaints were initiated by state legislatures in some states and administrative agencies in other states. These campaigns were aimed at addressing concerns that affected individuals were largely unaware of their rights under federal parity laws.[219]

TABLE 1. TYPES OF POLICY TOOLS USED TO ENFORCE FEDERAL PARITY LAWS

While this list of policy tools is not exhaustive, it provides some insight as to how states have differed in their enforcement of federal parity laws. And, the finding of state variation of enforcement of federal parity laws has been documented by the U.S. Government Accountability Office[220] and advocacy groups like the Kennedy Foundation.[221]

Future empirical research will need to be conducted to determine the efficacy of these various enforcement mechanisms. However, I predict that policy tools involving active monitoring and investigation of claims by administrative agencies will be more successful than those that rely on consumer action. Persons with a SUD that are trying to access treatment are likely doing so amidst a crisis and requiring them to navigate complicated insurance complaint processes if they are denied care is not only objectively ineffective, it is cruel.

A. Practical Implications

What implications do the findings of this Article have for the future of parity enforcement? Studies commissioned by the federal agencies responsible for enforcing federal parity laws have found violations of the federal law,[222] and advocacy groups monitoring

219. *See* 215 ILL. COMP. STAT. 5/370c.1(h).

220. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-150, MENTAL HEALTH AND SUBSTANCE USE: STATE AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES 15–20 (2019), https://bit.ly/2zcJlom [https://perma.cc/4RUG-MKHT].

221. Douglas et al., *supra* note 178, at 7–15 (using a Statutory Coding Instrument ("SCI") to assess state-level mental health parity statutes and observing the variations between states).

222. *See* GOPLERUD, *supra* note 185, at 52; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-63, MENTAL HEALTH AND SUBSTANCE USE: EMPLOYERS' INSURANCE COVERAGE MAINTAINED OR ENHANCED SINCE PARITY ACT, BUT EFFECT

parity compliance have scored states on their parity enforcement laws, demonstrating the need to rethink the current parity enforcement scheme.[223] Even Congress has indicated wavering confidence in federal parity enforcement by mandating responsible federal agencies to publish reports that detail enforcement efforts every two years.[224]

I reviewed these reports to determine whether federal oversight of state enforcement has increased or whether financial incentives have been introduced. Instead, I found that the federal agencies view their role in enforcement as (1) investigating parity violation claims for ERISA plans, (2) issuing guidance in interpreting the federal parity laws, and (3) encouraging policy diffusion of innovative state policy tools. For example, the Department of Labor has published its own model self-compliance worksheet.[225] HHS has reported publishing 44 FAQs[226] to help guide the states in enforcing parity, including an FAQ tailored specifically to the opioid crisis and parity.[227] HHS also created a website that directs consumers to the proper enforcing authority based on their insurance plan type, as well as other educational material on federal parity laws.[228] Further, federal enforcing agencies have investigated complaints made through their respective reporting channels. The Department of Labor has reported investigating over 1,700 claims and finding 300 violations since 2010.[229] Despite the line-by-line, laundry lists detailing page after page of federal agency actions to enforce parity, states continue to score low on parity enforcement report cards created by advocacy groups. And there is evidence of continued gaps in enforcement by state governments.[230]

OF COVERAGE ON ENROLLEES VARIED 69–102 (2011), https://bit.ly/2Wr7Aa0 [https://perma.cc/P778-ETKR]

223. *See* PARITY TASK FORCE REPORT, *supra* note 155, at 21–28; *see also* Douglas et al. *supra* note 178, at 2.

224. 21st Century Cures Act, Pub. L. No. 114-255, § 13001, 130 Stat. 1033, 1278–83 (2016).

225. *See generally* EMP. BENEFITS SEC. ADMIN., U.S. DEP'T OF LABOR, SELF-COMPLIANCE TOOL FOR THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ("MHPAEA") (2018), https://bit.ly/2SFECSO [https://perma.cc/HU8A-U78Q].

226. PARITY TASK FORCE REPORT, *supra* note 155, at 4.

227. U.S. DEP'T OF HEALTH & HUMAN SERVS., ACTION PLAN FOR ENHANCED ENFORCEMENT OF MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE 2 (2018), https://bit.ly/3fx3INN [https://perma.cc/RSE3-C5VY].

228. *Mental Health and Addiction Insurance Help*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://bit.ly/2ULqZDr [(last visited Feb. 22, 2020).

229. SECRETARY R. ALEXANDER ACOSTA, U.S. DEP'T OF LABOR, PATHWAY TO FULL PARITY 7 (2018), https://bit.ly/3b5sK2N [https://perma.cc/M73F-MV2C].

230. *See* PARITYTRACK, *supra* note 18.

Recommendations and Conclusion

Given the information presented in this Article, how can the current enforcement scheme be improved to make the enforcement of federal parity laws more likely? The current parity implementation scheme is already a cooperative arrangement between federal and state policy actors—one in which states are not relegated to technical implementers. The arrangement takes advantage of the expertise of state insurance enforcement agencies and allows states to address state needs. However, like the HIPPA enforcement scheme reviewed in Section II.C.2., the federal parity enforcement scheme lacks at least two primary components: (1) it lacks federal funding to help offset the costs of implementing federal law, and (2) it lacks reporting requirements and active federal oversight.

Financial incentives that support state enforcement of federal parity laws are necessary to encourage state compliance. Since state insurance commissioners are already investigating and enforcing violations of state insurance law, financial incentives for federal parity enforcement can be framed as a way to offset the state's fixed costs and variable costs for proactively monitoring and investigating potential parity violations.

Financial incentives can be made conditional on the submission of annual reports detailing state enforcement activities and on the adoption of best practices. The mandatory reports will provide federal agencies with data needed for proper oversight. Moreover, state financial incentives should be accompanied by the appropriation of federal funds to HHS earmarked for parity enforcement oversight. While such federal oversight may not be needed indefinitely to ensure parity enforcement, it is necessary to ensure the actualization of a national standard that will serve as the minimum level of parity acceptable.

Without these needed adjustments, persons with health insurance coverage will continue to report difficulties in accessing SUD treatment due to inadequate network coverage or denials for treatments improperly deemed as not medically necessary. While parity is by no means the only tool or even the primary tool for combating the nation's overdose crisis, it is valuable tool and one that, if properly institutionalized, can have a long-lasting impact on the way that generations of Americans access necessary care.

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