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Finding Parity Through Preclusion: Novel Mental Health Parity Solutions at the State Level

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ABSTRACT

Recently, the federal government has taken numerous steps to promote the equal treatment (also known as parity) of mental and physical health issues. The two most impactful actions are the Mental Health Parity and Addiction Act of 2008 and the Affordable Care Act. These acts focus on the traditional avenue for parity change—insurance regulation. While these acts have improved parity, major gaps in coverage and treatment between mental health/substance use disorder treatment and medical/surgical treatment persist. ERISA Preemption, evasive insurer behavior, lack of enforcement, and lack of consumer education continue to plague patients and healthcare professionals. On its own, federal insurance regulation is not doing its job. While the extent of the problem varies by state, the United States is nowhere close to full mental health parity.

Nonetheless, the push towards full parity continues at the state level. This Comment analyzes the parity efforts of four states: Illinois, Massachusetts, Delaware, and Pennsylvania. Each state represents a different approach to mental health parity. While some states focus on traditional insurance regulation, others enact broad changes that address specific practical and social challenges in behavioral health care. This Comment will analyze each state's actions beyond typical parity metrics and consider the holistic impact of the state's actions on the entire behavioral health system. Ultimately, this Comment will make

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two major recommendations. First, federal and state governments must broaden their view of parity to include implicit barriers to care outside of insurance coverage and treatment rates. Second, true parity requires states to pair stringent insurance regulation with community sourced action plans designed to mitigate current issues in the behavioral health system.

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I. INTRODUCTION

When you break your arm, you wear a cast. When you have the flu, you look pale and sickly. When you have chickenpox, you are covered in a rash. Physical illnesses generally have concrete signs perceivable by the sick and the community. Often, the sick and the community can clearly see that medical treatment is neces-

sary. The community encourages the sick to receive treatment, and a provider addresses the illness.

In contrast, mental health problems often do not have the same visible symptoms of disease.[1] Concealed from the public, mental health issues can fester untreated and dismantle emotional health until the problem explodes into crisis. Often, when the illness finally becomes apparent, the afflicted has already suffered substantial harm.[2]

Even when the mental health problem is obvious, social and cultural barriers impede access to treatment.[3] Stigma motivates the sick to ignore the issue and avoid seeking treatment.[4] The same stigma may prevent loved ones from encouraging the sick to receive care. To avoid the appearance of weakness, the sick may avoid confiding in friends and family. Further, the afflicted may not know the signs of mental health problems or the treatment options available due to a lack of knowledge and education.[5]

Even if the individual receives mental health treatment, his or her struggle is not over. Rising healthcare costs means most patients cannot pay for consistent mental health treatment without health insurance.[6] For patients fortunate enough to have insurance, the length, consistency, and quality of their care likely depends on their insurance.[7] Unfortunately, many insurers do not provide mental health benefits at the same rate as physical health benefits.[8] Patients face higher out-of-pocket costs, limitations on the length of treatment, and rates of coverage denial for medical services.[9]

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1. MAYO CLINIC, *Mental Illness*, https://mayocl.in/3ewyVk3 [https://perma.cc/6NG8-A5V8] (last visited Nov. 5, 2020) (listing primarily non-physical symptions of mental illness).

2. MENTAL HEALTH AMERICA, *B4Stage 4: Changing the Way We Think About Mental Health*, https://bit.ly/2IcKRLM [https://perma.cc/RRJ7-KBZV] (last visited Nov. 5, 2020) (listing progressive stages of mental illness where worsening symptoms infere with life activites and roles).

3. DEP'T OF HEALTH & HUM. SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY 29 (2001) (describing cultural norms that lead to individuals not seeking mental health treatment).

4. *Id.*

5. *See infra* Section II.D.4.

6. DEP'T OF HEALTH & HUM. SERVS., *supra* note 3, at 164 (explaining financial barriers to mental health treatment for minorities without health insurance).

7. *Id.*

8. Stacey A. Tovino, *State Benchmark Plan Coverage of Opioid Use Disorder Treatments and Services: Trends and Limitations*, 70 S.C. L. REV. 763, 782–97 (2019) (examining modern disparities in coverage between mental and physical health treatment).

9. *Id.*

Recognizing the situation, the federal government took some measures to facilitate access to mental health treatment.[10] In an attempt to ensure equal treatment of mental and physical conditions, Congress passed a series of mental health parity laws.[11] Mental health parity laws require insurers to cover physical and mental health conditions at the same rate.[12] Congress's action, while helpful, is limited in scope, and massive gaps between mental and physical health treatment remain.[13] Parity issues persist but are often not addressed, covered, or enforced by federal law. The federal parity laws are a step towards parity but remain just that: a step on the path to a larger, yet unachieved goal.

Facing the disparities infecting federal law, states have become the innovators of parity. Acting as laboratories of democracy,[14] states have developed unique strategies to tackle their parity problems.[15] These solutions often incorporate both traditional insurance regulation and novel solutions outside established arenas of change.[16] By taking an expansive view of parity, propoents of novel solutions consider the social barriers to mental health treatment required to effectuate truly equal physical and mental health treatment.

This Comment will analyze in detail the novel state solutions of Illinois, Massachusetts, Delaware, and Pennsylvania. To complete this analysis, Part II of this Comment will define mental health parity, give an overview of modern health insurance, and discuss the development of mental health treatment and parity law in the United States. This Comment will limit the scope of its analysis to private health insurance and will exclude analysis of public insurance plans such as Medicare and Medicaid.[17] Part II.D will then

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10. *See infra* Section II.C.

11. *See infra* Section II.C.

12. NAT'L INSTIT. ON MENTAL ILLNESS, *What is Mental Health Parity?*, https://bit.ly/2NeEdUZ [https://perma.cc/J52B-ND6A] (last visited Nov. 5, 2020).

13. Michael Barnes, *Achieving Real Parity: Increasing Access to Treatment for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 557 (2014) (maintaining that the United States has not yet achieved mental health parity).

14. New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("[A] State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

15. *See infra* Section III.A.

16. *See infra* Section III.A.

17. *See* Centers for Medicare and Medicare Services (CMS) & HHS, Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's

explain the modern barriers to mental health parity, including ERISA preemption, techniques used by insurers to avoid paying for mental health treatment, ineffective parity enforcement, and lack of parity education.[18] Part III will explore the details of Illinois, Massachusetts, Delaware, and Pennsylvania's parity.[19] Recognizing that it is too early to properly evaluate the success of the reform efforts, this Comment will argue for an expansive view of mental health parity. Expansive parity should be enforced by traditional insurance regulation and supplemented by innovative solutions that work to address social barriers to mental health treatment.

II. BACKGROUND

A. What is Mental Health Parity?

Mental health parity is the equal payment and treatment of physical health conditions and mental health (MH) and substance use disorders (SUD).[20] Importantly, parity does not always ensure quality treatment but ensures only equal treatment.[21] Legislators and commentators traditionally confine parity analysis to insurance plans.[22] In this framework, insurance plans achieve parity when they cover physical and mental health equally.[23] However, factors such as stigma, lack of education, and subtle exclusionary methods by insurers often prevent equal treatment even when coverage is facially equal.[24] Additionally, as this Comment will discuss, even legally mandated parity is difficult to enforce.[25] To guarentee MH and SUD services are actually proliferated at an equal rate, the United States must adopt a broader view of parity beyond traditional insurance plan regulation.

Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18389 (codified at 42 C.F.R. 438, 440, 456, 457) (describing parity requirements for certain Medicaid and CHIP plans).

18. *See infra* Section II.D.

19. *See infra* Section III.

20. NAT'L INSTIT. ON MENTAL ILLNESS, *What is Mental Health Parity?*, https://bit.ly/2NeEdUZ [https://perma.cc/3A9S-8YD5] (last visited Nov. 4, 2019).

21. *Id.*

22. *See, e.g.*, Tovino, *supra* note 8, at 782–97.

23. *Id.* at 772 (explaining history of parity solely in context of insurance plans).

24. *See, e.g.*, John V. Jacobi et. al., *Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform*, 120 PENN. ST. L. REV. 109, 113 (2015) (advocating for targeted enforcement of the ACA in light of typical private insurer exclusionary practices); Jeremy P. Ard, Comment, *An Unfulfilled Promise: Ineffective Enforcement of Mental Health Parity*, 26 ANNALS HEALTH L. ADVANCE DIRECTIVE 77–80 (2017) (explaining educational barriers to parity).

25. Ard, *supra* note 24 at 177.

B. Overview of Health Insurance in the United States[26]

The two general categories of health insurance in the United States are public and private health insurance.[27] Federal and state governments primarily fund public insurance, which includes Medicare and Medicaid.[28] States set plan standards and private funding, while private insurers may administer Medicaid programs.[29] Private insurance encompasses plans that the state does not primarily fund.[30]

Legislation breaks the private health insurance market into subgroups.[31] Individuals can obtain plans in either the individual or group market.[32] In the group market, an employer maintains a group health plan through which employees receive insurance coverage.[33] Employers with 51 or more employees offer group health plans in the large group market,[34] while the small group market covers employers with 50 or less employees.[35] A group plan can either be fully insured or self-insured.[36] For a fully insured plan, an outside entity, usually a private insurance company, bears the risk.[37] For a self-insured plan, a private company may act as an administrator, but the employer fully funds and bears the risk.[38] The individual market encompasses all private insurance offered outside of a group health plan.[39]

C. Development of Mental Health Parity in the United States

During most of United States history, society treated individuals with mental illness with disdain, abuse, and abhorrent medical

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26. Although this Comment will briefly discuss differences in state Medicaid plans, this Comment will primarily focus on private insurance.

27. *See* Barnes, *supra* note 13, at 559.

28. *Id.* at 560.

29. *Id.*

30. UNITED STATES CENSUS BUREAU, *Current Population Survey (CPS) Health Insurance Definitions,* https://bit.ly/36ogdaH [https://perma.cc/X6A6-6EGM] (lasted visited Nov. 5, 2020) (distinguishing private and public health insurance).

31. 42 U.S.C. § 18024(a) (2010).

32. *Id.* § 18024(a)(2)–(3).

33. *Id.* § 18024(a)(1).

34. *Id.* § 18024(b)(1).

35. *Id.* § 18024(b)(2).

36. Amy Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139, 146 (2012).

37. *Id.*

38. *Id.*

39. 42 U.S.C. § 18024(a)(2) (2010).

procedures.[40] In line with society's impressions, most physicians saw SUD as a moral failing caused by lack of self-control.[41] While these false perceptions still inform stigma, professionals began to view mental illness and SUD as treatable medical conditions in the mid-20th century.[42] At the same time, many health insurance providers continued to offer less coverage for MH/SUD conditions than for physical health conditions.[43] The federal government responded to this injustice by enacting three major statutes to promote MH/SUD parity: the Mental Health Parity Act of 1996[44] (MHPA), the Mental Health Parity and Addiction Equity Act of 2008[45] (Equity Act), and the Affordable Care Act[46] (ACA).

1. The Mental Health Parity Act of 1996 (MHPA)

Congress bungled the first attempt at federally mandated mental health parity, the MHPA,[47] by drastically limiting the MHPA's scope and offering many exceptions.[48] To start, the MHPA mandated only that plans could not have higher annual or lifetime maximum coverage spending limits for mental health services over physical health services.[49] The MHPA applied only to group health plans that already offered mental health coverage; the MHPA did not require plans to offer mental health coverage.[50] The MHPA exempted all employers with 50 or fewer employees.[51] Most egregiously, despite 35 percent of men and 18 percent of

40. Benjamin D. Heller, Comment, *Revolutionizing the Mental Health Act of 2008*, 47 SHLR 569, 573 (2017).

41. RICHARD DAVENPORT-HINES, THE PURSUIT OF OBLIVION: A GLOBAL HISTORY OF NARCOTICS 62 (1st ed. 2001).

42. Heller, *supra* note 40, at 574.

43. *Id.* at 576.

44. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874, 2949 (1996) [hereinafter *MHPA*].

45. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 100-343 §§ 511–12, 122 Stat. 3881 (codified at 29 U.S.C. § 1185a & 42 U.S.C. § 300gg-26 (2012)) [hereinafter *Equity Act*].

46. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified primarily in various sections of Titles 5, 18, 20, 21, 25, 26, 31, and 42 of the United States Code (2010)) [hereinafter *ACA*].

47. MHPA, *supra* note 44, at 2949.

48. Barnes, *supra* note 13, at 565.

49. MHPA, *supra* note 44, at 2948.

50. *Id.* at 2949. By 1985, 97% of employer-fianced health insurance plans provided some out-patient mental health coverage, albeit often with more limitations than physical health coverage. Allan P. Blostin, MENTAL HEALTH BENEFITS FINACED BY EMPLOYERS, MONTHLY LABOR REVIEW 23, 24 (1987) [available at https://bit.ly/3iOExqe [https://perma.cc/39YC-ED6V]].

51. MHPA, *supra* note 44, at 2949.

women having at least 1 episode of SUD during their lifetime at the time of enactment,[52] the MHPA did not cover SUD treatment.[53]

2. *The Mental Health Parity and Addiction Act of 2008 (Equity Act)*

In 2008, Congress took a substantial yet limited step on the road to parity. The Equity Act expanded many parity provisions of the MHPA.[54] Unlike the MHPA, the Equity Act expressly includes SUD treatment.[55] The Equity Act requires financial requirements to be no less restrictive than "substantially all medical and surgical benefits covered by the plan" for plans that offer MH/SUD benefits.[56] The financial requirements include "deductibles, copayments, coinsurance, and out-of-pocket expenses,"[57] a clear improvement over the mere restrictions on annual limits in the MHPA.[58] The Equity Act also requires equivalent treatment limitations such as number of visits[59] and coverage for out-of-network providers.[60]

While the process took many years and required multiple revisions, various government agencies eventually passed the final regulations enacting the Equity Act in late 2013.[61] The regulations established two categories of treatment limitations: quantitative treatment limitations (QTL), which are limitations expressed numerically; and non-quantitative treatment limitations (NQTL), which "otherwise limit the scope or duration of benefits or treatment" such as medical management standards, prior authorization, and formulary design.[62] The Equity Act divides benefits into discrete classifications.[63] Classifications include in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency care, and prescription drugs.[64] Plans that provide medical/surgical coverage and MH/SUD coverage cannot

52. CENTER FOR DISEASE CONTROL AND PREVENTION, HEALTH UNITED STATES 1995, 32 (1995), https://bit.ly/2X42sbT [https://perma.cc/TE3F-QXF7].
53. MHPA, *supra* note 44, at 2949.
54. See Equity Act, *supra* note 45 (explaining expansion of parity).
55. 29 U.S.C. § 1185a(a)(1) (2012).
56. *Id.* § 1185a(a)(3)(A)(i).
57. *Id.* § 1185a(a)(3)(B)(i).
58. Barnes, *supra* note 13, at 566.
59. 29 U.S.C. § 1185a(a)(3)(B)(iii).
60. *Id.* § 1185a(a)(5).
61. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68239, 68240–41 & n.2 (Nov. 13, 2013) [hereinafter *Final Rules*].
62. 29 C.F.R. §§ 2590.712(a), (c)(4)(i)–(ii) (2012).
63. 29 C.F.R. § 2590.712(c)(2)(ii) (2012).
64. *Id.* § 2590.712(c)(2)(ii) (2012); 45 C.F.R. § 146.136(c)(iv)(2)(ii) (2013).

impose any financial requirement or treatment limitation on MH/SUD treatment that is more restrictive than the predominant financial requirement for medical/surgical benefits in the same classification.[65] For MH and SUD coverage, insurance plans can impose only NQTL restrictions that are "comparable" and applied no less stringently than standards used for medical/surgical benefits in the same classification.[66] Insurers must also disclose certain information such as medical necessity requirements.[67]

Despite these requirements, parity gaps continued.[68] Coverage for MH and SUD was still not mandatory.[69] Moreover, two major exceptions remained. First, small-employer plans with 50 or fewer employees and individual plans were immune from Equity Act provisions.[70] Second, the Equity Act contained a "Cost Exemption," which allowed a plan issuer to claim exemption from Equity Act provisions if the total cost of the health plan increased by more than two percent the first year or more than one percent in subsequent years.[71] The regulations also created some ambiguity. The regulations refused to enumerate specific services that plans must cover within the classifications and left that decision to the states.[72] Further, the comparative standard can be difficult to apply as MH/SUD treatment often has different clinical requirements than physical health.[73]

3. Affordable Care Act

The ACA further expanded mental health parity, mandated MH and SUD coverage for many plans, and helped close some Equity Act coverage gaps, although certain exemptions remain.[74] The

65. 29 C.F.R. § 2590.712(c)(2)(i). Predominant financial restrictions are restrictions that apply to two-thirds of all medical/surgical benefits. *Id.* § 2590.712(c)(3)(B).

66. *Id.* § 2590.712(c)(4)(i). NQTL restrictions are not limited to those explicitly enumerated in the regulation. *Final Rules*, *supra* note 60, at 68246.

67. 29 C.F.R. § 2590.712(d)(1) (2012). Medical necessity standards are the criteria insurers use to determine if a plan covers a treatment. *Id.*

68. Ard, *supra* note 24, at 70.

69. 29 U.S.C. § 1185a(b)(1) (2013).

70. *Id.* § 1185a(c)(1).

71. *Id.* § 1185a(c)(2).

72. *Final Rules*, *supra* note 61, at 68246.

73. Emma Peterson and Susan Busch, *Achieving Mental Health and Substance Use Disorder Treatment Parity: A Quarter Century of Policy Making and Research*, 39 ANN. REV. PUB. HEALTH 421, 430 (2018) (describing difficulty in comparing complex treatments for severe MH conditions to medical/surgical treatments).

74. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified primarily in various sections of Titles 5, 18, 20, 21, 25, 26, 31, and 42 of the United States Code (2010)).

ACA created exchanges for individuals to purchase health insurance.[75] Every Qualified Health Plan (QHP) an insurer sells in the exchange must cover all Essential Health Benefits (EHB), which includes MH and SUD benefits.[76] All "non-grandfathered"[77] plans in the individual and small group markets must also cover EHBs.[78] The Department of Health and Human Services (HHS) passed regulations that mandate MH and SUD benefits provided as an EHB must follow Equity Act provisions.[79] As a result, all plans that have EHBs must also comply with the Equity Act, expanding the scope of the Equity Act well beyond large group plans.[80]

While the ACA ushered in significant change, some exemptions remain. Large employers—which regulations define as employers with over 100 full-time employees—do not need to offer EHBs.[81] Large employers must instead offer a plan that covers at least 60 percent of employee health costs.[82] If large employers do choose to offer MH and SUD benefits, the plan must comply with the Equity Act.[83] The ACA also does not compel any self-insured plans to offer EHBs.[84]

While the ACA requires many plans to provide EHBs, the exact benefits and extent of benefits that plans must cover is statutorily unclear.[85] To help clarify required benefits, HHS passed regulations in 2013 that required states to select or be selected into a benchmark plan.[86] The benchmark plan was a plan sold in 2012 that contained coverage in all ten EHB categories.[87] All health plans that were required to cover EHBs were required to provide health benefits "substantially equal" to those in the benchmark

75. *See generally* 45 C.F.R. § 155 (2013) (creating and establishing standards for exchanges under the ACA).

76. 42 U.S.C. § 18021(a)(1)(B); 42 U.S.C. § 18022(b)(1)(E) (2010).

77. *See* 42 U.S.C. § 18011(e) (2010). Grandfathered plans are group health plans that individuals enrolled in before the effective date of the ACA. *Id.* ("[T]he term 'grandfathered health plan' means any group health insurance coverage to which this section applies.").

78. 42 U.S.C. § 18021(b)(1)(A) (2010) (applying EHBs mandates to individual and small group markets health plans).

79. 45 C.F.R. § 156.115(a)(3) (2013).

80. *Id.*

81. 42 U.S.C. § 18032(f)(2)(B)(i)–(ii) (establishing that a state may, but is not required, to allow large group market insuers to offer qualified health plans through an exchange, making only certain large employers "qualified employers" for EHB purposes).

82. 26 U.S.C. § 36B(c)(2)(c)(ii) (2010).

83. 29 U.S.C. § 1185a(1) (2012).

84. 42 U.S.C. § 18021(b)(1)(B) (2010).

85. Stacey A. Tovino, *A Right to Care*, 70 ALA. L. REV. 183, 201–03 (2018).

86. 45 C.F.R. § 156.100 (2019).

87. *Id.* § 156.110(a)(5).

plan.[88] In 2015, with similar mandates, HHS required states to choose a second benchmark plan from plans sold in 2014.[89]

In 2018, HHS published a new rule that gave states more flexibility.[90] HHS gave states the option to select a new third benchmark plan.[91] If a state wanted to choose a new plan, the state had three options: (1) select another state's second benchmark plan; (2) replace one or more categories of the state's current EHBs with the same category or categories of EHBs set forth in another state's second benchmark plan; or (3) select an entirely new benchmark plan with certain restrictions.[92] By selecting a benchmark plan, the state had the unique opportunity to specifically articulate what a plan must cover to comply with state parity standards.[93]

D. Barriers to Parity

While these legislative acts promote parity, significant barriers persist.[94] This section will discuss four specific barriers: ERISA preemption,[95] evasive insurance behavior,[96] fractured enforcement,[97] and lack of consumer education.[98]

1. ERISA Preemption

Congress passed the Employee Retirement Security Act of 1974 (ERISA),[99] in part, to federally regulate Employee Benefit Plans and to reduce compliance difficulties for employers.[100] Courts have interpreted ERISA to broadly preempt two types of state law claims.[101] First, ERISA preempts state law claims if they "relate to" an ERISA plan.[102] Courts interpret "relate[s] to"

88. *Id.* § 156.115(a).
89. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10749, 10812 (Feb. 27, 2015) (to be codified at 45 C.F.R. 144, 147, 153–56, 158).
90. *See* 45 C.F.R. § 156.111(a).
91. *Id.*
92. *Id.*; Tovino, *supra* note 86, at 203-05 (citing 45 C.F.R. § 156.111(a) (2019)).
93. Tovino, *supra* note 86, at 204–207.
94. *See infra* Section II.D.
95. *See infra* Section II.D.1.
96. *See infra* Section II.D.2.
97. *See infra* Section II.D.3.
98. *See infra* Section II.D.4.
99. *See* 29 U.S.C. § 1001–1461 (1974).
100. 29 U.S.C. § 1001 (1974).
101. *See, e.g.*, Popoola v. Md.-Individual Practice Ass'n, 244 F. Supp. 2d 577, 580 (D. Md. 2003) (explaining how courts look to both the preemption provision and civil enforcement provision of ERISA when applying the preemption doctrine).
102. 29 U.S.C. § 1144(a) (2006).

broadly; they give the phrase its common sense meaning of having a connection or relation to an ERISA plan.[103] This definition excludes most state common law and statutory claims, including those relating to the improper retention of benefits such as wrongful death.[104] Second, Section 502 of ERISA limits the remedies the insured can invoke to protect his or her rights under the plan.[105] Section 502 limits the obtainable remedy to enforcing plan terms with no tort liability.[106] Focusing on congressional intent to create a universal legislative scheme, the Supreme Court held that Section 502 preempts "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement . . . ."[107] Federal courts therefore will remove any state law claims for state law remedies to federal court where the court will likely dismiss for failure to state a claim.[108]

The introductory case, *Andrews-Clarke v. Travelers*,[109] discusses the modern implications of ERISA preemption.[110] In *Andrews-Clarke*, the court explains the shift from fee-for-service to Managed Care Organizations.[111] Under the fee-for-service model, a patient would receive medical care and then bill the insurer.[112] If the insurer wrongly denied coverage, the insured would need to sue to cover costs.[113] Recovery of costs is the main remedy under ERISA and completely sufficient in this scheme.[114] Under the Managed Care system, insurers typically conduct a review *before* providing care.[115] Denial can lead to much more than financial harm as the plan may deny the insured vital medical care.[116] While the insured may request an injunction under ERISA, injunctions are often impractical due to time constraints or the incapacity of the

103. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (establishing general "relate to" standard).

104. *See, e.g.*, Yardly v. U.S. Healthcare, 698 A.2d 979, 987 (Del. Super. Ct. 1996) (holding plaintiff's wrongful death claim as preempted).

105. 29 § U.S.C. 1131(a) (2006).

106. *Id.* § 1131(a)(1)(B).

107. Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004).

108. *See* Yardly, 698 A.2d at 988 (providing an example of state claims barred due to preemption).

109. Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 57–64 (D. Mass. 1997).

110. *Id.*

111. *Id.* at 59.

112. *Id*. at 58.

113. *Id*.

114. *Id.* at 58; 29 § U.S.C. 1132(a)(1)(B) (2006).

115. Andrews-Clarke, 984 F. Supp at 59.

116. *Id.*

patient.[117] Accordingly, ERISA's wide preemptory net often leads wronged policyholders without any real remedy.[118]

However, ERISA does not preempt all state legislation or common law directed towards employer health plans.[119] ERISA has a "savings clause" that shields from preemption state laws that "regulate insurance, banking, or securities."[120] The Supreme Court uses a "common-sense" standard to interpret this provision; a state law must have an impact on the insurance industry *and* the state legislature must also specifically direct the law towards the insurance industry to fall under the savings clause.[121] In *Kentucky Ass'n of Health Plans v. Miller*,[122] a unanimous Court articulated two requirements for a plan to fall under the savings clause.[123] The state law must specifically be directed towards entities engaged in insurance and must substantially affect the risk pooling arrangement between the insurer and the insured.[124]

Courts limit the preemptive shield by the "exception with exemption" labeled the deemer clause.[125] The deemer clause prevents legislators and courts from considering an insurance, bank, or trust company for purposes of state law seeking to regulate such companies.[126] Most courts have held that the deemer clause shields self-insured plans from state laws directed at insurance usually protected under the savings clause.[127] The deemer clause creates a protective bubble for self-insured plans outside state legislative reach.[128]

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117. *Id.*

118. *Id.*

119. *See* Schneider v. Unum Life Ins. Co. of America, 149 F. Supp. 2d 169, 190 (E.D. Pa. 2001) (holding ERISA does not preempt Pennsylvania state insurance law due to savings clause).

120. 29 U.S.C. § 1144(b)(2)(A) (2006).

121. Pilot Life Ins. Co., 481 U.S. at 50 (1987).

122. Ky. Ass'n. of Health Plans v. Miller, 538 U.S. 329 (2003).

123. *Id.* at 342.

124. *Id.*

125. 29 U.S.C. § 1144(b)(2)(B) (2006); Ky. Ass'n. of Health Plans, 538 U.S. at 336 n.1.

126. 29 U.S.C. § 1144(b)(2)(B) (2006); Ky. Ass'n. of Health Plans, 538 U.S. at 336 n.1.

127. *See, e.g.*, Metropolitan Life Ins. Co. v. Mass., 471 U.S. 724, 746–47 (1985) (holding that fully-insured plans can be subject to regulation directed towards insurance business while self-insured plans cannot); Wadsworth v. Whaland, 562 F.2d 70, 77–78 (1st Cir. 1977) (limiting scope of deemer clause to self-insured plans). *But see* Northern Group Services, Inc. v. Auto Owners Ins. Co., 833 F.2d 85, 94 (6th Cir. 1987) (holding that interest in national uniformity must outweigh interest in state regulation to bar operation of state law under deemer clause).

128. *See Wadsworth*, 562 F.2d at 77.

2. Evasive Insurer Behavior

Even with the legal expansion of parity, many insurers are still not equally covering mental and physical health services.[129] For example, private insurers pay 13 to 14 percent less for in-network mental health services than Medicare, despite paying up to 12 percent more for other specialties.[130] Other studies have shown that 20 percent of large-group plans still require higher co-payments,[131] and 28 percent of plans had stricter precertification requirements for MH/SUD treatment.[132] Insurers and state regulators often use specific techniques to limit actual payments for MH/SUD treatment such as narrowing the definition of "medical necessity"[133] and "mental illness,"[134] using excessive prior authorization,[135] and limiting consumer education.[136]

a. Medical Necessity

One technique to limit MH/SUD coverage is to narrowly construe medical necessity standards for MH/SUD treatment.[137] Generally, medical necessity determines if a treatment is an accepted treatment that meets community standards of care.[138] However, federal law does not concretely define "medical necessity."[139] States and insurers are free to craft their own definitions as long as the benefits "[are] consistent with generally recognized independent standards of current medical practice."[140] Varied definitions can lead to vast disparities in coverage among states and greatly weaken access to MH/SUD care in states with narrow definitions.[141]

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129. *See* DARIA PELECH & TAMARA HAYFORD, CONG. BUDGET OFFICE, *Medicare Advantage and Commercial Prices for Mental Services*, 38 HOSPITALS, HEALTH IT & MORE NO. 2, 262 (2019) [available at https://bit.ly/2CxHUzh [https://perma.cc/484A-UDQH]].

130. *Id.*

131. Jacobi, *supra* note 24, at 174.

132. Peterson & Busch, *supra* note 74, at 427.

133. *See infra* Section II.D.2.a.

134. *See infra* Section II.D.2.b.

135. *See infra* Section II.D.2.c.

136. *See infra* Section II.D.2.d.

137. Joni Roach, Comment, *Discrimination and Mental Illness: Codified in Federal Law and Continued by Agency Interpretation*, 2016 MICH. ST. L. REV. 269, 285–88 (2016).

138. *Id.* at 288–89.

139. 29 C.F.R. § 2590.712(a) (2012) (defining medical/surgical benefits using only vague medical necessity requirements).

140. *Id.*

141. Roach, *supra* note 138, at 306–07.

The final rules of the Equity Act classify "medical necessity" as a NQTL that plans must uniformly apply to physical health and MH/SUD treatment.[142] However, statistical and widespread anecdotal evidence shows universal application is not occurring; insurers frequently deny MH/SUD treatments for lack of medical necessity.[143] Physical and mental illnesses also have acute clinical differences that certain medical necessity definitions may not adequately address.[144] Additionally, medical necessity disputes create uncertainty for courts, patients, and providers and can lead to long claim-resolution disputes and litigation.[145]

b. Defining Mental Illness

As this Comment has discussed, federal parity legislation compels most insurance plans to offer mental health coverage.[146] However, no federal definition of "mental illness" exists.[147] Without federal guidance, states must craft their own definitions.[148] States have taken numerous approaches to this issue.[149] Some states use a specific medical organization's manual such as the Diagnostic and Statistical Manual of Mental Disorders (DSM).[150] Other states make a distinction between "severe" and "non-severe" or "biologically" and "non-biologically" based illnesses.[151] Even others articulate specific covered and uncovered illnesses.[152] Naturally, inconsistent state definitions can lead to disparities in treatment for certain mental health conditions among states.[153]

c. Prior Authorization

Parity regulation includes Prior Authorization as a NQTL.[154] Despite explicit regulation, insurers use prior authorization to fur-

142. 29 C.F.R. § 2590.712(c)(4)(i) (2012).

143. NAT'L ALLIANCE ON MENTAL ILLNESS, A LONG ROAD AHEAD 4 (2015) [available at https://bit.ly/2qRlMwQ [https://perma.cc/CYY2-HMEJ]].

144. Heller, *supra* note 40, at 588–89.

145. *See, e.g.*, Roach, *supra* note 137, at 286 ("Since states define mental illness in different ways, the availability of mental-health benefits may depend on where an individual resides.").

146. *See supra* Section II.B.2.b–c.

147. Roach, *supra* note 137, at 286–87.

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.* at 288.

154. *See* 29 C.F.R. § 2590.712(c)(2)(i) (2012) and attached factual scenarios (explaining prior authorization is a treatment limitation that plans must apply equally to medical/surgical and MH/SUD treatment).

ther restrict MH/SUD coverage.[155] Prior authorization requires the insured to obtain a guarantee that a plan will cover a treatment before receiving the treatment; without this authorization, a plan will not cover the treatment.[156] The benchmark plan of 28 states requires a form of prior authorization for some type of substance abuse related care.[157] If a plan does not enforce the same requirements for parallel physical health benefits, then the plan violates federal parity law.[158]

3. Ineffective Parity Enforcement

Lack of diligence at the state level assists evasive insurer behavior.[159] For example, in likely violation of federal parity law, Alabama and Mississippi's benchmark plans have QTLs that apply to MH/SUD only.[160] Insurers can often get away with legally questionable, evasive behavior due to fractured, ineffective enforcement of mental health parity.[161]

The agency that enforces parity law changes pursuant to the type of health plan in question.[162] The Employee Benefits Security Administration (EBSA) of the Department of Labor has jurisdiction over ERISA-regulated private employer-sponsored group plans subject to the Equity Act.[163] Most day-to-day enforcement falls on EBSA Benefits Advisors stationed throughout the country.[164] HHS has primary authority for only state and local government employee group health plans.[165] Accordingly, states (usually through insurance commissioners or attorneys generals) have primary authority over plans in the individual and fully-insured group markets.[166] However, HHS can gain primary authority for these plans if a state elects not to enforce or fails to enforce the Equity

155. Tovino, *supra* note 8, at 787.

156. *Id.*

157. *Id.*

158. *Id.* at 788.

159. Ard, *supra* note 24, at 76.

160. Tovino, *supra* note 8, at 794.

161. *See generally* Ard, *supra* note 24 (articulating specific failures in enforcement of mental health parity).

162. EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES, THE MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY TASK FORCE FINAL REPORT 14–15 (2016), https://bit.ly/370FMxN [https://perma.cc/43UH-UWHD].

163. *Id.* at 14.

164. *Id.*

165. *Id.*

166. *Id.* at 15.

Act.[167] Despite this authorization, HHS has intervened in only four states.[168]

The 21st Century Cures Act ("Cures Act"), passed in 2016, expanded EBSA and HHS authority to conduct parity audits of health plans.[169] The Cures Act also clarified disclosure requirements and provided detailed examples of compliance and non-compliance.[170] However, while federal and state audits have uncovered significant parity violations, the impact of the Cures Act is unclear as it allocates no additional permanent funding to finance the audits.[171]

States have a lot of power in this scheme as they are the primary enforcers of parity law for non-ERISA plans in 46 states.[172] However, state enforcement actions are rare.[173] Therefore, enforcement often requires consumer action.[174] If the appeals process fails, the only option the consumer has is bringing a lawsuit against the plan or administrator.[175] The Equity Act affords no explicit private right of action, which limits the effectiveness of private lawsuits.[176] Consumers then must bring a claim under ERISA; if their plan is not an ERISA-regulated plan, consumers may have no claim and therefore no remedy.[177]

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167. *Id.*

168. *Id.* These states are Missouri, Oklahoma, Texas, and Wyoming. *Id.*

169. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (Dec. 13, 2016) (codified primarily in various sections of Title 5, 18, 21, 26, 29 and 42 of the United States Code).

170. 42 U.S.C. §§ 300gg-26(a)(6)(B)(i)(I), (a)(7)(A) (2012).

171. *Id.*; *see* Jessica Scarbrough, Note, *Notes & Recent Transactions Comments: The Growing Importance of Mental Health Parity*, 44 AM. J. . L. & MED. 453, 466 (2018) (outlining funding restrictions).

172. *See* EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES, THE MENTAL HEALTH & SUBSTANCE USE DISORDER PARITY TASK FORCE FINAL REPORT 14 (2016), https://bit.ly/370FMxN [https://perma.cc/43UH-UWHD].

173. Sarah Goodell, *Health Police Brief*, HEALTH AFFAIRS 4 (Nov. 9, 2015), https://bit.ly/3569lip [https://perma.cc/TSQ7-4HCE] ("Enforcement actions by states are not common.").

174. Ard, *supra* note 24, at 77–80.

175. *Id.*

176. *Id.* at 80; Am. Psych. Assoc. v. Anthem Health Plans, 50 F. Supp. 3d. 157, 161 (D. Conn. 2014), aff'd 821 F.3d 352 (2d. Cir. 2016) ("Although there is no private right of action under the Parity Act, portions of the law are incorporated into ERISA and may be enforced using the civil enforcement provisions in ERISA § 502, to the extent they apply.").

177. *Am Psych. Assoc.*, 50 F. Supp. at 161; Ard, *supra* note 24, at 81.

4. Lack of Consumer Education

The burden of enforcing parity often falls, directly or indirectly, on the consumer.[178] However, most consumers are unable to effectively carry this burden due to ignorance of parity law.[179] In 2014, only 13 percent of all adults who used insurance to pay for MH treatment were aware of the term "mental health parity" and therefore likely would not spot a violation.[180] Procedural ignorance creates further difficulties as internal review procedures and the proper agency with whom to file an external review may not be clear.[181] While some information may be available online, no official government source consolidates all necessary information in one accessible location.[182] These difficulties impede consumers from filing legitimate complaints despite clear violations.[183]

III. ANALYSIS

A. State-by-state Analysis

Despite significant federal legislative effort, substantial barriers to mental health parity persist.[184] Recognizing the continuing parity problem, many states have initiated novel solutions.[185] Understandably, most state solutions are legal solutions; states pass new or modify existing insurance regulations to promote parity.[186] However, legal solutions are not the only solutions. Other states find answers outside of the traditional legal framework.[187] These answers often effectively supplement pure legal change.[188] The below states—Illinois, Massachusetts, Delaware, and Pennsylania—illuminate the range of potential parity strategies between tradi-

178. *See supra* Section II.C.3.

179. Ard, *supra* note 24, at 77–78.

180. Peterson & Busch, *supra* note 73, at 429.

181. Ard, *supra* note 24, at 78.

182. *See Model Resources*, PARITYTRACK (2019), https://bit.ly/38v8jeW [https://perma.cc/PVC8-BF56] (consolidating contact information for scattered parity enforcement resources).

183. Peterson & Busch, *supra* note 73, at 429.

184. *See supra* Section II.

185. *See generally* David Chorney, Comment, *The Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMEDICAL L. 215 (2014) (providing overview of various state parity laws and legal innovations that effectuate parity).

186. *Id.*

187. *See infra* Section III.A.1-4.

188. *Parity Resource Guide for Addiction and Mental Health Consumers, Providers and Advocates*, THE KENNEDY FORUM (2015), https://bit.ly/2TQxCnM [https://perma.cc/9RWC-CGDZ] (rating states with non-legal parity solutions higher than strictly legal states).

tional pure legal regulatory changes, innovative non-legal solutions, and combinations of both.

1. Illinois

Illinois has focused on legal solutions for parity.[189] As this Comment previously discussed, Illinois was the only state to implement a new, third benchmark plan pursuant to HHS's 2018 Final Regulations.[190] This entirely new plan, which implements the 2018 Final Regulation's third option, will take effect in 2020.[191]

Illinois's plan offers many provisions that improve MH/SUD parity.[192] The plan removes most obstacles to Medication-Assisted Treatment, including prior authorization, dispensing limits, fail first policies, and lifetime limit requirements.[193] The plan covers telepsychiatry to the same extent as all other Medical Care visits.[194] Additionally, the plan requires coverage of at least one intranasal opioid reversal agent[195] with initial prescriptions of high strength opioids.[196] Importantly, all of these mandates apply only to plans that are required to cover EHBs.[197]

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189. Press Release, State of Ill. Dep't of Ins., Statement from Illinois Dept. of Insurance on Interpretation of Federal Mental Health Parity Law (Jan. 5, 2011), https://bit.ly/3k7qmgF [https://perma.cc/ZX4P-FBJZ]. *See also* CENTER FOR MEDICARE & MEDICAID SERVICES, ILLINOIS EHB BENCHMARK PLAN (2018), https://go.cms.gov/38yzntK [https://perma.cc/K8LF-5NQA].

190. *See generally* ILL. DEP'T OF INS., THE ACCESS TO CARE AND TREATMENT (ACT) PLAN (2018) [hereinafter *ACT Plan*], https://go.cms.gov/38yzntK [https://perma.cc/4UW8-W4LK] (describing Illinois' benchmark plan changes).

191. *Id.* at 2.

192. *Id.*; *Evaluating State Mental Health and Addiction Parity Statutes*, KENNEDY-HATCHER CENTER FOR MENTAL HEALTH EQUITY (2018), https://bit.ly/2I5xYn2 [https://perma.cc/7NS4-A3KR] (rating Illinois 100 out of 100 points for Illinois' parity statutes).

193. ACT Plan, *supra* note 190, at 21.

194. *Id.* at 11 ("Benefits are available for Medicare Care visits when . . . you utilize telepsychiatry care.").

195. Intranasal opioid reversal agents is a medication (Naloxone Hydrochloride Nasal Spray) administered via a nasal spray used to reverse opioid overdoses. Rachael Rzasa Lynn & JL Galinkin, *Naloxone Dosage for Opioid Reversal: Current Evidence and Current Implications*, 9 THER ADV. DRUG SAF. 63, 63–64 (2018). Narcan is the most popular intranasal reversal agent, but the Food and Drug Administration (FDA) recently approved the first general nasal spray. FDA News Release, Food & Drug Admin., FDA Approves First Generic Naloxone Nasal Spray to Treat Opioid Overdose (Apr. 19, 2019), https://bit.ly/3863k3A [https://perma.cc/KJA2-Y7PF].

196. ILL. DEP'T OF INS., THE ACCESS TO CARE AND TREATMENT (ACT) PLAN 32 (2018), https://go.cms.gov/38yzntK [https://perma.cc/GV4E-FWBY].

197. *See infra* Section II.C.3.

Illinois law also strongly encourages parity through medical necessity standards.[198] Uniquely, the insurer does not unilaterally choose the reviewing physician whenever the plan and insured dispute over the medical necessity of treatment for serious mental illness.[199] Instead, the patient, insurer, and patient's provider jointly select the reviewing physician in the patient's specialty.[200] For SUD review, plans are required to adhere to the standards of the American Society of Addiction Medicine.[201]

Another important legal change comes not from state legislation but from the Illinois Department of Insurance.[202] The Department decided to resolve all ambiguity in the Equity Act in favor of the insured.[203] The Department's decision led to the Department siding with the insured on most insurance disputes.[204] Arguably, this philosophy takes the enforcement burden off the consumer while encouraging careful plan administration.[205]

Cumulatively, these legal reforms have greatly improved Illinois's MH/SUD parity law.[206] Parity Track, which grades the quality of each state's parity statutes, grades Illinois's statutes at 100 out of 100 possible points.[207] However, MH/SUD parity in Illinois, while much better than average, is nowhere near complete.[208] Out-

198. 215 ILL. COMP. STAT. ANN. 5/370c(b)(3) (West 2019).

199. *Id.*

200. *Id.* (stating that an insurer must offer medical review by a provider "jointly selected by the patient, patient's provider, and insurer").

201. *Id.* (stating that medical necessity requirements "shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine").

202. Press Release, Ill. Dep't of Ins., Statement from Illinois Dept. of Insurance on Interpretation of Federal Mental Health Parity Law (Jan. 5, 2011), https://bit.ly/3k7qmgF [https://perma.cc/QQ5D-8R79].

203. *Id.* Recently, the Illinois Department of Insurance conducted market conduct examinations and fined multiple insurers for violations of federal parity law. *See, e.g.*, Ill. Dep't of Ins., Illinos Department of Insurance Mental Health Parity Market Conduct Examination Reports of Cigna Healthcare of Illinois, Inc. (July 2020), https://bit.ly/2Fjji21 [https://perma.cc/8X43-TXH3] (fining Cigna over 550 thousand dollars for violations of parity law).

204. Press Release, Ill. Dep't of Ins., Statement from Illinois Dept. of Insurance on Interpretation of Federal Mental Health Parity Law (Jan. 5, 2011), https://bit.ly/2Gs5xeB [https://perma.cc/QQ5D-8R79].

205. *Id.*

206. *Evaluating State Mental Health and Addiction Parity Statutes*, KENNEDY-HATCHER CENTER FOR MENTAL HEALTH EQUITY (2018), https://bit.ly/2I5xYn2 [https://perma.cc/7NS4-A3KR] (rating Illinois 100 out of 100 points for Illinois' parity statutes).

207. *Id.*

208. STEVE MELEK ET AL., ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: WIDENING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT 46 (2d ed. 2019).

of-network utilization for commercial PPO plans is over 3.5 times higher for behavioral care than medical/surgical care for inpatient facility, behavioral outpatient facility, and office visits for primary care.[209] Office visit in-network reimbursement rates for behavioral health are around nine percent lower than medical/surgical rates.[210] Clearly, Illinois has not fully achieved MH parity.

Illinois, through traditional means, has taken significant legal strides but is far from fully accomplishing MH/SUD parity.[211] Helpful reforms from other states, encompassing legal and non-legal change, may supplement traditional efforts to push progress towards complete parity.[212]

2. Massachusetts

Massachusetts combines insurance regulation and innovative non-traditional reform to improve MH/SUD parity. Massachusetts focused its recent insurance regulatory efforts on two changes.[213] First, legislation passed in 2016 requires all insurers to cover SUD evaluations without prior authorization.[214] Here, Massachusetts is trying to thwart insurers' efforts to subtly utilize NQTLs more frequently for SUD by preventing the use of NQTLs entirely.[215] Second, Massachusetts strengthened reporting requirements for insurers.[216] In addition to general information about the total number of grievances that plan participants filed the previous year, insurers must provide a report detailing the number of medical or surgical claims versus MH/SUD claims submitted by participants.[217] The report must dictate the percentage of those respective claims denied by the insurer.[218] The insurer must also report the number

209. *Id.* (examining statistics from 2017).

210. *Id.* (examining statistics from 2017).

211. *Id.* Illinois insurance regulation reforms also do not apply to self-insured plans due to ERISA preemption. *See supra* notes 209–210.

212. *See infra* Section III.2-3.

213. *See Statutory Overview in Massachusetts*, PARITYTRACK, https://bit.ly/2Gogn53 [https://perma.cc/9MY7-ZYDJ] (last visited Oct. 20, 2020) (explaining recent statutory developments in Massachusetts law).

214. MASS. GEN. LAWS ch. 175, § 47GG (2019) ("Any policy . . . shall provide coverage for medically necessary acute treatment services and medically necessary clinical stabilization services for up to a total of 14 days and shall not require preauthorization . . . .")

215. Melek, *supra* note 208, at 54 (establishing disparity in NQTL utilization among Massachusetts insurers through 2017 data showing higher out of network utilization rates and lower reimbursement rates for behavioral health care compared to medical/surgical care).

216. MASS. GEN. LAWS ch. 176O, § 7 (2019).

217. *Id.* § 7(b)(5).

218. *Id.*

of claims denied due to each specific NQTL—for example, the number of claims denied because of medical necessity or failure to obtain a referral.[219]

Additionally, regulations fortify enforcement of these parity provisions.[220] Passed in 2018, the provisions grant the Insurance Commissioner investigative authority towards both insurers and any subcontracting entity that has administrative or other authority.[221] The Commissioner can investigate whenever she determines a party "may be engaging in or has engaged in a pattern of noncompliance with [State or Federal] Mental Health Parity Law."[222]

Massachusetts augments its regulatory efforts with unique programs that promote MH/SUD parity.[223] First, Massachusetts created the Behavioral Health Task Force to evaluate systemic issues in MH/SUD care and propose ways to save lives and money through MH/SUD reform.[224] The Task Force recommended creating a mental health care program that could provide emergency mental health services around the clock during a MH crisis.[225]

Following the Task Force's recommendation, Massachusetts created the Emergency Services Program (ESP).[226] The ESP provides services around the clock for individuals who are experiencing a behavioral health crisis.[227] The ESP focuses on mobility and strives to deliver services in the home or other community settings to reduce emergency department visits and provide the least restrictive care possible.[228] The ESP emphasizes that speed and availability of treatment when "[intervention] in the earliest possible point in the crisis episode . . . contributes to the prevention of adverse outcomes, such as arrest, [among others]."[229] Once an individual is

219. *Id.*

220. 211 MASS. CODE REGS. 154.04 (2018) (codifying regulations for enforcement of parity law).

221. 211 MASS. CODE REGS. 154.04(4) (2018).

222. *Id.*

223. *See, e.g.*, BEHAVIORAL HEALTH INTEGRATION TASK FORCE, REPORT TO THE LEGISLATURE AND THE HEALTH POLICY COMMISSION 6 (2013), https://bit.ly/2I4Y8Cp [https://perma.cc/8A6M-VTEH].

224. *Id.* at 4.

225. *Id.* at 36–37.

226. MASS. BEHAVIORAL HEALTH P'SHIP, EMERGENCY SERVICES PROGRAM (ESP) FOR THE 4 ESPS CURRENTLY OPERATED BY THE MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH IN THE SOUTHEAST REGION OF THE STATE, INCLUDING BROCKTON, CAPE COD AND THE ISLANDS, FALL RIVER, AND TAUNTON/ATTLEBORO 1 (2015), https://bit.ly/2Vpi7DP [https://perma.cc/KA48-Z2EN].

227. *Id.* at 3.

228. *Id.* at 6 ("Mobile (non-hospital) response: *the preferred service delivery model*.").

229. *Id.* at 5.

stabilized, the ESP facilitates and coordinates access to other treatment services.[230] The ESP promotes parity by providing greater access to MH/SUD services and promoting transitions to appropriate long-term care.[231]

Unfortunately, the impact of ESP is somewhat limited because, by default, ESP is reimbursed by public insurance only.[232] Accordingly, unless an ESP forms a separate agreement with a commercial plan, only individuals with public insurance can access the ESP.[233]

3. Delaware

Like Massachusetts, Delaware implements a mixture of insurance regulation and non-traditional strategies to promote MH/SUD parity.[234] To start, Delaware passed a series of impactful legislative and regulatory changes in May 2017, which introduced a host of new requirements for insurers.[235] The legislation prohibits prior authorizations for all non-prescription SUD treatment, including inpatient treatment.[236] Individual and large group plans cannot require concurrent review of the first 14 days of SUD treatment if the facility uses the American Society of Addiction Medicine (ASAM) clinical review tool and can deny reimbursement upon retroactive review only if the treatment was not necessary using ASAM standards.[237] Insureds in an inpatient behavioral health facility do not have to pay the facility for any care provided besides copayments, coinsurance, or deductibles.[238] Individual and large group plans must also provide five days of "emergency" medication without prior authorization for MH and SUD disorders (including opioid reversal agents).[239]

Recent legislation further strengthens prescription parity.[240] Delaware health benefit plans that provide for prescription drugs must place at least one formulation of the FDA-approved Medica-

230. *Id.* at 7.

231. *Id.* at 3-4 (explaining how the ESP increases ease of access and links with other community-based providers).

232. *Id.* at 4.

233. *Id.*

234. *See infra* notes 236–44.

235. S.B. 41, 149th Gen. Assemb. (Del. 2017).

236. DEL. CODE ANN. tit. 18, § 3343(d)(1)(b) (2019).

237. *Id.* § 3343(d)(1)(c).

238. *Id.* § 3343(d)(1)(e).

239. *Id.* § 3343(b)(2)(a).

240. H.B. 220, 150th Gen. Assemb. (Del. 2019).

tion Assisted Therapy (MAT) drugs[241] on the lowest tier of the plan's prescription drug formulary and cover the drug without prior authorization.[242] Additionally, a formulation of each MAT drug must be available without step-therapy on every tier of the formulary.[243] Plans must also cover fees associated with dispensing methadone[244] at opioid treatment programs.[245]

While Delaware's insurance regulation efforts are already impressive, Delaware's work outside the traditional legislative sphere truly exemplifies fruitful paths to parity.[246] The cornerstone of Delaware's progress is the Behavioral Health Consortium, which brought together physicians, addiction specialists, community advocates, healthcare professionals, and more to formulate an action plan to tackle behavioral healthcare issues in Delaware.[247] Members of the Consortium used public input to map out current issues in Delaware's behavioral health system.[248] The Consortium used this input to create an action plan that has led to a host of improvements, including Delaware's overdose system of care.[249] The system of care, the first of its kind in the United States, establishes stabilization centers for patients after they are released from hospitals or by first responders.[250] The system of care increases parity by mitigating the difficulty of finding recovery centers and increases the accessibility of MH/SUD care, which allows patients to utilize MH/SUD care to the same extent as medical/surgical care.[251]

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241. These drugs include Buprenorphine, Naltrexone, Naloxone, and a product containing both Buprenorphine and Naloxone. DEL. CODE ANN. tit. 18, § 3343(b)(3)(a)–(d) (2019).

242. DEL. CODE ANN. tit. 18, § 3343(b)(2)(a) (2019).

243. *Id.* § 3343(d)(1)(f).

244. Methadone is a medication used in the detoxification and maintenance of patients dependent on opioids. Ilene B. Anderson & Thomas E. Kearney, *Use of Methadone*, 172 WEST. J. MED. 43, 43 (2000).

245. DEL. CODE ANN. tit. 18, § 3343(b)(4) (2019).

246. *See* BEHAVIORAL HEALTH CONSORTIUM, THREE-YEAR ACTION PLAN 12-42 (2018), https://bit.ly/3cbKb3s [https://perma.cc/XHP8-HBXT] (outlining numerous efforts towards improving behavioral health system in Delaware besides insurance regulation) [hereinafter *Consortium*].

247. *Id.* at 32.

248. *Id.* at 8-10.

249. Zoë Read, *Gov. Carney Signs Legislation Establishing Nation's First Overdose Care System*, WHYY PBS (Sept. 11, 2018), https://bit.ly/2RsgoLS [https://perma.cc/AWS7-EEQD].

250. *Id.*

251. *See Constorium*, supra note 246, at 13 (establishing the need for an overdose system of care).

The action plan led to various other reforms that improve parity outside of insurance regulation.[252] Responding to the lack of consumer education on Mental Health Resources, Delaware partnered with Google to help patients and families find MH/SUD care under its insurance plans.[253] Delaware also partnered with Shatterproof, a non-profit organization that rates addiction treatment centers, to ensure parity extends beyond quantity of care into quality of care.[254] Delaware also provided funding to three school districts to provide additional Mental Health education and services in school, promoting parity by increainsg understanding of mental health and reducing stigma which prevents individuals from seeking care.[255] By bringing stakeholders together and creating an action plan, Delaware sparked innovative parity reform.

4. Pennsylvania

Unlike Illinois, Massachusetts, and Delaware, Pennsylvania has not passed substantial recent insurance regulation aimed to promote MH/SUD parity.[256] Instead, Governor Tom Wolf's administration privately negotiated with commercial insurers in an attempt to lower the administrative barriers to MAT.[257] Bringing their MAT coverage in line with Pennsylvania Medicaid, the commercial insurers agreed to cover most MAT without prior authorization, including Methadone, Naltrexone, and nasal naloxone.[258] Insurers will also cover MAT at the lowest patient tier cost on the relevant plan.[259]

While beneficial, the agreement's effectiveness is limited. The agreement does not specify how Pennsylvania will enforce the

252. *See id.* at 12–31 (outlining various reforms to promote parity that will or already have occurred).

253. Del. Health & Soc. Servs. et al., *DHSS Partners with Google, Partnership for Drug-Free Kids to Bring Online Resources to Delaware Families*, DELAWARE.GOV (Nov. 21, 2019), https://bit.ly/3aIXW93 [https://perma.cc/SH9K-U4J8].

254. Del. Health & Soc. Servs. et al., *Delaware to Partner with Shatterproof to Develop Addiction Treatment Rating System Nationwide*, DELAWARE.GOV (Apr. 26, 2019), https://bit.ly/2RtpCHy [https://perma.cc/K8JE-LC8Q].

255. Del. Dep't of Ed. et al., *Delaware Receives $9M Federal Grant to Expand Mental Health Support in Schools*, DELAWARE.GOV (Sept. 24, 2018), https://bit.ly/2NVmSAD [https://perma.cc/A52S-3VWG].

256. *See generally Statutory Overview in Pennsylvania*, PARITYTRACK, https://bit.ly/3p0mRMH [https://perma.cc/AKU7-LCXL] (last visited Nov. 5, 2020) (listing recent statutory advancements in Pennsylania law).

257. *Wolf Administration Announces Agreement with Insurers to Eliminate Barriers to Medication Assisted Treatment*, PA.GOV (Oct. 12, 2018), https://bit.ly/36ungfC [https://perma.cc/93MM-J3K7].

258. *Id.*

259. *Id.*

agreement upon insurer breach.[260] Only the largest commercial insurers participated in the agreement, limiting the scope of change.[261] Moreover, the agreement does not apply to self-insured plans.[262]

B. Analysis of Effectiveness

The discussion above outlines three different approaches to parity: complete overhaul of insurance regulation, piecemeal regulatory change mixed with non-traditional legislative and non-legislative action, and private negotiation without legislation.[263] Comparing the effectiveness of each approach is difficult. To start, no uniform metric of MH/SUD parity exists to compare between states.[264] Data tracking behavioral health usage does not account for stigma or lack of consumer education that prevents individuals from seeking care in the first place.[265] Even without stigma, scholars have found no foolproof way to compare usage of healthcare versus prevalence of disease for medical/surgical and MH/SUD conditions.[266] Second, nearly all of these reforms are recent.[267] The reforms have simply not had enough time to make their systemic impact.[268]

However, interested parties can consult some imperfect markers of parity to examine a state's parity situation.[269] The Mental Health Treatment and Research Institute commissioned the Mil-

260. *Id.* (listing no enforcement mechanism).

261. *Id.* The participating insurers are Aetna, Capital BlueCross, Geisinger, Highmark, Independence Blue Cross, UPMC, and United Healthcare. *Id.*

262. *Id.* ("Self-funded plans, where employers provide health care coverage administered by a third party, are regulated by the federal government and are not included in this agreement.").

263. *See supra* Section III.A.1-4.

264. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-150, MENTAL HEALTH AND SUBSTANCE USE STATE AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES 33 (2019) (explaining that states must rely on consumer complaints to conduct parity investigations instead of relying on a particular metric).

265. *See Consortium*, *supra* note 246, at 17 (listing changing perceptions and stigma as an integral problem in Delaware's behavioral health system).

266. Aubrey Chamberlin, Note, *Stop the Bleeding: A Call for Clarity to Achieve True Mental Health Parity*, 20 WIDENER L. REV. 253, 264-265 (2014) (explaining difficulty and unequal nature of applying physical illness standards to medical necessity determinations for MH treatment).

267. *See, e.g.*, Del. Health and Soc. Servs. et al., *DHSS Partners with Google, Partnership for Drug-Free Kids to Bring Online Resources to Delaware Families*, DELAWARE.GOV (Nov. 21, 2019), https://bit.ly/3aIXW93 [https://perma.cc/V2JJ-TCP9] (occurring within the past year).

268. *Id.*

269. *See, e.g.*, Melek, *supra* note 208, at 9–10 (explaining a methodology of NQTL disparity analysis).

liman Research Report, which compared out-of-network usage and reimbursement rates for behavioral health versus medical/surgical health services.[270] The nationwide data confirms the United States has not achieved MH/SUD parity in commercial insurance.[271] In 2017, insureds in PPO Plans used out-of-network healthcare for behavioral health over five times more often than medical/surgical health for inpatient facilities, outpatient facilities, and office visits.[272] In-network commercial reimbursement rates to providers for behavioral health, relative to Medicare reimbursement rates, were also substantially lower.[273] These numbers show insurers are not reimbursing at the same rates for physical and MH/SUD care.

The state data paints a clear picture. Illinois MH/SUD parity in commercial insurance plans is ahead of Massachusetts, Delaware, Pennsylvania, and the nation but is still not complete anywhere.[274] For example, Illinois out-of-network usage rates in PPO plans are about 4 times higher for both behavioral health inpatient and outpatient facility visits, while Massachusetts's rates are 10.46 and 7.64 times higher, Delaware's rates are 29.08 and 13.14 times higher, and Pennsylvania's rates are 18.33 and 9.97 times higher.[275] Despite existing disparities, the data sends a clear message. Targeted insurance regulation, such as that propagated by Illinois, effectuates MH/SUD parity.

However, insurance regulation does not create full MH/SUD parity. Insurers find ways to circumvent even extensive targeted

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270. *Id.*

271. *Id.* at 26-27 (showing 2017 disparity in out-of-network usage between behavioral health benefits and medical/surgical benefits).

272. *Id.* at 26-31.

273. *Id.* at 135 (showing disparity in rates of reimbursement compared to Medicare in 2017 PPO plans).

274. *Id.* at 46. In Commercial PPO plans nationally, for a behavioral health condition, an insured is 5.24 times more likely to use out-of-network care for an inpatient facility visit, 5.72 times more likely for an outpatient facility visit, 5.41 times more likely for a primary care office visit, and 4.04 more likely for a specialist office visit. *Id.* In Pennsylvania, the respective numbers are 18.33 times, 9.97 times, 5.73 times, and 3.93 times. *Id.* at 71. In Massachusetts, 10.46 times, 7.64 times, 5.48 times, and 5.39 times. *Id.* at 54. In Delaware, 29.08 times, 13.14 times, 3.47 times, and 6.40 times. *Id.* at 41. In Illinois, 4.25 times, 4.69 times, 3.58 times, and 2.55 times. *Id.* at 46.

275. *Id.* at 135–139 (showing state-by-state disparity in rates of reimbursement compared to Medicare in 2017 PPO plans). The data is from 2017, so states had not yet fully implemented many of the reforms discussed in this comment. *See, e.g.*, Del. Health and Soc. Servs. et al., *DHSS Partners with Google, Partnership for Drug-Free Kids to Bring Online Resources to Delaware Families*, DELAWAREGOV (Nov. 21, 2019), https://bit.ly/3aIXW93 [https://perma.cc/V2JJ-TCP9] (occurring within the past year).

legislation.[276] Further, social factors, unreachable by traditional plan regulation, impede the recognition and treatment of behavioral health disorders.[277] Behavioral health conditions will not be covered with the same quality as medical/surgical conditions until behavioral health conditions are recognized and treated to the same extent as medical/surgical conditions. Because of existing barriers to MH/SUD treatment, progress on the road to MH/SUD parity necessarily requires looking beyond insurance into the social climate that surrounds MH/SUD treatment.

In acknowledging and addressing the stigmatized reality of MH/SUD care, the value of unique reform such as action in Massachusetts and Delaware shines through. Currently, scholars have no means to quantify the reform's true contribution to parity. Metrics measure coverage for treatment only once an individual seeks treatment, and the current reform is too recent.[278] However, Massachusetts and Delaware understand the unique challenges of treating stigmatized, misunderstood disease. The ESP in Massachusetts provides care at home for patients that may not be able to leave; the overdose system of care in Delaware transitions patients to further treatment for individuals who may not have otherwise sought follow-up care.[279] Delaware breaks down the stigma by providing funding in schools to help educate children about mental health. By adjusting treatment paths in light of the specific needs of the behavioral health patient, these reforms aim towards achieving true parity, where behavioral health conditions are recognized, treated, and covered with the same quality and completeness as medical/surgical conditions.

The foundation of parity is still grounded in strong insurance regulation. Specifically, states should follow Illinois and require commercial insurers to reimburse for telepsychiatry, cover opioid reversal agents, and remove administrative barriers to MAT like prior authorization, step therapy, and fail first policies.[280] States should also follow Illinois's lead on medical necessity by granting decision-making powers only to providers jointly selected by plan

276. U.S. GOV'T. ACCOUNTABILITY OFFICE, GAO-20-150, MENTAL HEALTH AND SUBSTANCE USE STATE AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES 31 (2019) (examining specific GAO findings of noncompliance with NQTL standards); *see infra* Section II.D.2.

277. *See Consortium*, *supra* note 246, at 26 (listing education as pivotal issue in Delaware's Behavioral Health System).

278. *See* Melek, *supra* note 208, at 9 (explaining methodology which only uses treatment actually offered).

279. *See supra* Section III.A.3.

280. *See supra* Section III.A.1.

and insured, as well as by using the ASAM for SUD coverage.[281] Like Illinois, ambiguity should be resolved in favor of the insured.[282] Like Massachusetts, non-prescription SUD treatment should not require prior authorization, insurers should report their behavioral health coverage denials in detail, and the Insurance Commissioner should have broad investigative authority.[283] Like Delaware, insurers should be required to provide emergency supplies of SUD medication without prior authorization, and MAT should be available on every tier of the plan's formulary.[284]

Nonetheless, reforms that holistically address the unique social position of behavioral health care must supplement regulation. States should follow Delaware and gather all stakeholders to illuminate issues in the behavioral health system and create an action plan.[285] Plans should consider consistent behavioral health barriers such as access, stigma, quality of care, and relapse. An ESP like Massachusetts may increase access, an overdose system of care may prevent relapse, and partnering with an organization like Shatterproof may increase quality of care.[286] All of these options push MH/SUD parity forward by encouraging the recognition and treatment of behavioral health conditions. While the best action plan for a state may vary, reform that touches beyond insurance regulation is necessary for true MH/SUD Parity.

IV. CONCLUSION

Despite federal action, disparities in coverage and treatment persist between mental and physical health. A significant reason for the continuing parity crisis is federal and state decisionmakers adopting a narrow view of parity. Assuming that equal coverage will lead to equal treatment, the narrow view of parity focuses solely on insurance regulation. This narrow view ignores the broader picture. Barriers to MH/SUD treatment, including stigma and unique medical challenges in MH/SUD care, neuter the reach and impact of MH/SUD care. True parity requires a system that contemplates these barriers.

However, the presence of implicit obstacles to MH/SUD care does not diminish the importance of insurance regulation. This Comment advocates for a two-tiered approach. First, states must

281. *See supra* Section III.A.1.
282. *See supra* Section III.A.1.
283. *See supra* Section III.A.2.
284. *See supra* Section III.A.3.
285. *See supra* Section III.A.3.
286. *See supra* Section III.A.2.

use insurance regulation to create a strong parity base that ensures equal insurance coverage for MH/SUD and physical healthcare. Next, using stakeholder input, states must implement non-traditional innovative solutions that address underlying issues in MH/SUD care. Without recognizing the unique struggles in MH/SUD healthcare, disparities will continue; states will not achieve parity. States can achieve true parity only through novel solutions that contemplate the distinct issues surrounding MH/SUD treatment.