



2014

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Recommended Citation

Michael C. Barnes and Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555 (2014).

Available at: <https://lawrepository.ualr.edu/lawreview/vol36/iss4/2>

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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

*Michael C. Barnes & Stacey L. Worthy**

I. INTRODUCTION

Richard Clarke had an alcohol use disorder.¹ Given that Richard had been drinking to excess on multiple occasions, his physician recommended enrollment in a thirty-day inpatient alcohol detoxification and rehabilitation program.² Yet, despite the fact that Richard's insurance policy explicitly stated that it covered such treatment, his insurer refused to approve it.³ Shortly after, Richard attempted to commit suicide by drinking a substantial amount of alcohol, ingesting cocaine, swallowing a handful of prescription drugs, and locking himself in his garage with the car engine running.⁴ The local district court ordered that Richard be committed to a thirty-day detoxification and rehabilitation program, and yet, Richard's insurance carrier still refused to cover such treatment.⁵ According to the court, "[b]y now, it was tragically apparent to everyone but [the insurer] that [Richard] was a danger to himself and perhaps others."⁶ As an alternative to inpatient treatment, the court ordered Richard to be committed to a local correctional facility for detoxification and rehabilitation.⁷ While there, he received little therapy or treatment.⁸ Less than a month after his release in October 1994, Richard purchased a six-pack of beer, attached a garden hose from the tailpipe of his car to the passenger compartment, and successfully committed suicide.⁹ In a suit brought by Richard's widow against the insurer, the court noted:

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1. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 50 (D. Mass. 1997).

2. *Id.* at 50–51.

3. *Id.* at 51.

4. *Id.*

5. *Id.*

6. *Id.*

7. *Andrews-Clarke*, 984 F. Supp. at 51.

8. *Id.*

9. *Id.* at 51–52.

As a consequence of [the insurer's] failure to pre-approve—whether willful, or the result of negligent medical decisions made during the course of utilization review—[Richard] never received the treatment he so desperately required, suffered horribly, and ultimately died needlessly at age forty-one.

....

This case, thus, becomes yet another illustration of the glaring need for Congress to amend [insurance laws] to account for the changing realities of the modern health care system.¹⁰

In August 2012, nearly twenty years after Richard Clarke's death, Michael Mitrano died despite seeking help from several treatment programs for a substance use disorder (SUD).¹¹ SUDs are diagnosed based on pathological patterns of behaviors related to use of particular substances¹² and are measured on a broad range of severity, from mild to severe, based on the presence of certain criteria.¹³ When discussing his son's death, Michael's father, Benedetto Mitrano, said, "Insurance always refused to pay for one reason or another . . . [Michael] was never 'sick enough.' My son is dead. Is he sick enough for them now?"¹⁴ Richard Clarke and Michael Mitrano are not alone. In 2011, 21.6 million people aged twelve or older suffered from SUDs, and yet an estimated 89.6% of them went untreated, creating a massive treatment gap.¹⁵ Of individuals surveyed between 2009 and 2012, 48.3% of those who sought addiction treatment claimed that a lack of

10. *Id.* at 52–53 (footnote omitted).

11. *Kennedy Calling for Equal Coverage of Mental Health —Yes, Still*, WBUR'S COMMONHEALTH REFORM & REALITY (Mar. 29, 2013, 1:31 PM), <http://commonhealth.wbur.org/2013/03/mental-health-parity-states> [hereinafter *Kennedy Calling for Equal Coverage*].

12. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483 (5th ed. 2013). Substances of abuse include alcohol; cannabis; hallucinogens (with separate categories for phencyclidine or similarly acting arylcyclohexylamines); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants), tobacco, and other (or unknown) substances. *Id.* at 481.

13. *Id.* at 484. Although the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) addresses each of nine specific classes as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), it states that the diagnosis of substance use disorder can be applied to all nine classes. Therefore, this document will refer to such disorders collectively as "substance use disorders" or "SUDs." The criteria for measuring the severity of an SUD can be found in DSM-5's section on SUDs. *See id.* at 483–84.

14. *Kennedy Calling for Equal Coverage*, *supra* note 11.

15. *Briefing on Substance Use Treatment and Recovery in the United States: Executive Summary*, SUBSTANCE USE AND MENTAL HEALTH SERVS. ADMIN., http://partnersforrecovery.samhsa.gov/docs/Briefing_Substance_Use_Treatment.pdf (last visited Mar. 31, 2014).

“health insurance or a benefit plan that covered addiction treatment” prevented them from actually obtaining such treatment.¹⁶

Despite the enactment of laws aimed at expanding access to health care—like the Mental Health Parity and Addiction Equity Act of 2008 (Equity Act) and the Patient Protection and Affordable Care Act of 2010 (ACA)—long-standing prejudices against and misunderstandings about SUDs have prevented access to care for those who suffer from such disorders.¹⁷

There are two main reasons why proper parity of SUD treatment with other medical or surgical needs is lacking. “First is the stigmatization of addictive disorders—the idea that [individuals with SUDs] do not deserve treatment because they cause their own illness[es].”¹⁸ Various studies have shown that SUDs, in particular, are highly stigmatized health conditions.¹⁹ In addition to the self-stigma that an individual with an SUD may place on himself and the social stigma perpetuated by society at large, there are also structural stigmas that contribute to the stigmatization of addictive disorders.²⁰ A “structural stigma refers to the rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatized groups.”²¹ Members of the healthcare industry, including insurance providers, may hold negative beliefs about individuals with SUDs—that they overuse system resources, are not invested in their own health, abuse the system through drug-seeking behavior and diversion²² of medications, or fail to adhere to recommended care.²³ These “perceptions can contribute to inequitable and poor provision of care for people with [such] disorders.”²⁴

The second reason why parity is lacking in SUD treatment and other medical or surgical needs concerns the misconception that SUD treatment is too expensive for society to afford.²⁵ According to the National Institute on Drug Abuse (NIDA), substance use costs the U.S. over \$600 billion per

16. David Mee-Lee, *Integrating Services for Co-Occurring Disorders and General Healthcare: How the ASAM Criteria Help*, ADDICTION HEALTH SUMMIT 2 (Feb. 28, 2014), <http://addictionhealthsummit.com/wp-content/uploads/2014/02/meelee-handout.pdf>.

17. Norman S. Miller & Robert M. Swift, *Primary Care Medicine and Psychiatry: Addictions Treatment*, 27 *PSYCHIATRIC ANNALS* 408, 408–09, 415 (1997).

18. *Id.* at 415.

19. James D. Livingston et al., *The Effectiveness of Interventions for Reducing Stigma Related to Substance Use Disorders: A Systematic Review*, 107 *ADDICTION* 39, 40 (2012).

20. *Id.* at 39–40.

21. *Id.*

22. Diversion “is defined as the transfer of a prescription drug from a lawful to an unlawful channel of distribution or use.” Khary K. Rigg et al., *Patterns of Prescription Medication Diversion Among Drug Dealers*, 19 *DRUGS: EDUC. PREVENTION & POL’Y* 145, 145 (2012).

23. Livingston et al., *supra* note 19 at 39–50.

24. *Id.* at 40.

25. *See, e.g.*, Jason Schwartz, *Too Expensive?*, ADDICTION & RECOVERY NEWS (Nov. 11, 2011, 5:39 AM), <http://addictionandrecoverynews.wordpress.com/2011/11/11/too-expensive>.

year.²⁶ However, it is more costly to let SUDs go untreated because SUD treatment reduces associated health and social costs by well over the cost of treatment itself.²⁷ For instance, “every [public] dollar invested in [SUD] treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft.”²⁸ In addition to the reduction in social costs, treating SUDs will provide further benefits to society, as well as the individual, as a result of “fewer interpersonal conflicts; greater workplace productivity; and fewer drug-related accidents, including overdoses and deaths.”²⁹

Yet, by exploiting the long-engrained stigma against SUDs, private and government insurers are impeding access to such treatment in order to reduce their health care spending. Insurance companies frequently offer comprehensive coverage for medical and surgical benefits but place severe limitations on coverage for SUD treatment.³⁰

Private and public insurers, including state Medicaid providers, are violating the Equity Act, and in some cases the ACA and state parity laws, when the quality and quantity of covered SUD treatment services are not equivalent to those of other covered physical health treatments. Federal and state governments must act to ensure access to adequate SUD treatment, to prevent discrimination, and to ensure that cost reductions are applied fairly. This Article serves as a guide for both legal representatives of individuals with SUDs who are unlawfully denied benefits and state lawmakers in a position to bolster state legislation on this issue. It instructs such individuals on how to recognize a violation of the law and how to bring various enforcement actions for noncompliance. It also recommends how states can take a more active role in access to care by enforcing federal parity laws and by implementing and enforcing more stringent state parity laws.

Part I of this Article provides background information, including a brief overview of the U.S. health insurance system, to provide a foundation and terminology for the remainder of the Article; the current status of the substance-use epidemic in the U.S., establishing a nationwide need for extensive access to treatment; and trends toward social acceptance of SUD treatment, paving the way for extensive federal and state legislation. It also provides an overview of such legislation, including the Equity Act, the ACA, and state parity laws and regulations as they pertain to coverage of SUD treatment. Part II discusses common insurance coverage restrictions

26. NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 12 (3d ed. 2012), available at http://www.drugabuse.gov/sites/default/files/podat_1.pdf.

27. *Id.* at 12–13.

28. *Id.* at 13.

29. *Id.*

30. Miller & Swift, *supra* note 17, at 415.

placed on SUD treatment and analyzes how such restrictions violate the Equity Act, the ACA, and state parity laws in light of the statutes, regulations, and emerging case law. Part III provides guidance on how to bring enforcement actions under these laws, and makes recommendations of ways in which states can take the lead by enacting and enforcing federal and state parity laws while fairly reducing health care costs.

II. BACKGROUND

A. Overview of Insurance Programs

To understand the laws governing insurers, it is important to first understand the basics of how private and government-funded insurance plans operate. This section provides a brief overview of the insurance system.

1. Private Insurers

Private insurance companies sell private health care plans to individuals as part of an individual plan or to employers as part of a group plan.³¹ “Group [p]lans are offered through an employer or association,” whereas an individual plan may be purchased independent of any affiliation.³² There are two main types of private plans: fee-for-service plans and managed care plans. Fee-for-service plans, also referred to as non-managed care plans, are private health care plans in which physicians charge patients directly; the insurance company then reimburses a specific percentage or set amount of the bill to the patient.³³ These plans allow for flexibility in choosing physicians and hospitals.³⁴ However, they are typically more expensive than other types of insurance plans.³⁵ Managed care plans are insurance plans that generally provide comprehensive service to their members and offer financial incentives for the patients to use the providers who are within their network.³⁶

31. *CPS Health Insurance Definitions*, U.S. CENSUS BUREAU, <https://www.census.gov/hhes/www/hlthins/methodology/definitions/cps.html> (last visited Apr. 28, 2014).

32. *Explanation of Health Insurance Terms and Coverages*, ALA. DEPARTMENT INS., <http://www.aldoi.gov/consumers/HealthInsExplain.aspx> (last visited Mar. 20, 2014).

33. *Healthcare Plan Information: Plan Types*, U.S. OFF. PERSONNEL MGMT., <https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-types/> (last visited Mar. 31, 2014).

34. *See id.*

35. *Id.*

36. *Definitions of Health Insurance Terms*, U.S. BUREAU LAB. STAT. 4 (Feb. 2002), <http://www.bls.gov/ncs/ebs/sp/healthterms.pdf>.

2. Medicaid

Medicaid is a joint federal-state entitlement program that pays for services on behalf of certain eligible low-income persons.³⁷ Within broad national guidelines, each state runs its own Medicaid program, and the Centers for Medicare and Medicaid Services (CMS) monitors the programs in each state.³⁸ States establish their own eligibility standards; determine the type, amount, duration, and scope of services; and set the rates of payment for services.³⁹

States may offer coverage through standard, state-run, fee-for-service Medicaid plans; Alternative Benefit Plans (ABPs); or managed care plans.⁴⁰ ABPs are a type of fee-for-service Medicaid benefits package that provide benchmark or benchmark-equivalent state plan benefits.⁴¹ As of January 1, 2014, all adults aged 19 to 65 without children or with dependent children who qualify for Medicaid will be enrolled in ABPs.⁴² “Benchmark” means that the benefits are at least equal to one of four plans specified in the ACA: (1) the Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program; (2) state employee coverage that is offered and generally available to state employees; (3) the commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state; and (4) secretary-approved coverage, which can include the Medicaid state plan-benefit package offered in that state.⁴³ “Benchmark-equivalent” means that the benefits include certain specified

37. Barbara S. Klees, Christian J. Wolfe & Catherine A. Curtis, *Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of the Social Security Act*, CENTER FOR MEDICARE & MEDICAID SERVICES 18 (Nov. 1, 2009), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2009.pdf>.

38. *Definitions of Health Insurance Terms*, *supra* note 36, at 3, 18.

39. Klees, Wolfe, & Curtis, *supra* note 37.

40. Mark Hayes, NAT'L ASS'N OF CMTY. HEALTH CTRS., MEDICAID PREMIUM ASSISTANCE AND HEALTH INSURANCE EXCHANGES: SPOTLIGHT ON THE STATES #5, at 3 (2013), available at <http://www.nachc.com/client/Exchange%20Issue%20Brief%205.pdf>.

41. 42 U.S.C. § 1396u-7(a)(1)(A) (2012); Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. 42,160, 42,160 (July 15, 2013) (to be codified at 42 C.F.R. pts. 431, 435, 436, 438, 440, 447 & 457; 45 C.F.R. pts. 155 & 156); CINDY MANN, CTRS. FOR MEDICARE & MEDICAID SERVS., SMDL # 12-003, STATE MEDICAID DIRECTOR LETTER RE: ESSENTIAL HEALTH BENEFITS IN THE MEDICAID PROGRAM 1 (Nov. 20, 2012), available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf>.

42. 42 C.F.R. § 435.119 (2013).

43. 42 U.S.C. § 1396u-7(b)(1)(A)-(D); Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. at 42,190; CINDY MANN, CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 41, at 1-2.

services and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages.⁴⁴

Under Medicaid managed care plans, individuals enroll with individual managed care organizations (MCOs).⁴⁵ MCOs make arrangements with state Medicaid agencies to deliver Medicaid health benefits and additional services in exchange for payment.⁴⁶ MCOs may provide services that fee-for-service plans are unable to provide, such as disease management and innovations in care coordination.⁴⁷

“Medicaid policies [on] eligibility, services, and payment are complex and vary considerably⁴⁸ Thus, a person who is eligible for Medicaid in one State may not be eligible in another State.”⁴⁹

B. An Overview of the Prescription Drug Epidemic, Substance Use Disorders, and Medication-Assisted Treatment

The Centers for Disease Control and Prevention (CDC) has officially declared that prescription drug abuse⁵⁰ in the United States is an epidemic.⁵¹ Recent data indicate that about 2 million people begin abusing prescription

44. 42 U.S.C. § 1396u-7(b)(2); Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, 78 Fed. Reg. at 42,190; CINDY MANN, CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 41, at 1.

45. JEAN HEARNE, CONG. RESEARCH SERV., RL30726, PRESCRIPTION DRUG COVERAGE UNDER MEDICAID 5 (2008).

46. *Id.*

47. Robert Book, *Benefits and Challenges of Medicaid Managed Care*, FORBES (Oct. 18, 2012, 10:09 PM), <http://www.forbes.com/sites/aroy/2012/10/18/benefits-and-challenges-of-medicare-managed-care/>.

48. Klees, Wolfe & Curtis, *supra* note 37, at 18.

49. *Id.*

50. “[P]rescription drug abuse is . . . ‘the intentional self-administration of a medication for a nonmedical purpose such as “getting high.”’ This . . . includes all degrees of medication use with the intention of experiencing a high, from teens swallowing pills from medicine cabinets to inveterate addicts ‘shooting’ morphine. Abuse and nonmedical use are synonymous for the purpose of this [A]rticle.” CTR. FOR LAWFUL ACCESS & ABUSE DETERRENCE, NATIONAL PRESCRIPTION DRUG ABUSE PREVENTION STRATEGY 7 (2010) (footnote omitted) (quoting N.P. Katz et al., *Challenges in the Development of Prescription Opioid Abuse-Deterrent Formulations*, 23 CLINICAL J. PAIN 648 (2007)), available at http://claad.org/wp-content/uploads/2013/10/2010_National_Strategy.pdf.

51. See Press Release, Ctrs. for Disease Control & Prevention, Opioids Drive Continued Increase in Drug Overdose Deaths (Feb. 20, 2013), available at http://www.cdc.gov/media/releases/2013/p0220_drug_overdose_deaths.html. The CDC defines “epidemic” as “[t]he occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.” *Epidemiology Glossary*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/reproductivehealth/Data_Stats/Glossary.htm (last updated Sept. 13, 2010).

pain relievers every year.⁵² In 2009, nearly 4.6 million emergency room visits were drug related, approximately 1.2 million of which involved misuse or abuse of pharmaceuticals.⁵³ In 2010, approximately 38,329 people died from drug overdoses in the United States.⁵⁴ Approximately sixty percent of those “deaths (22,134) involved pharmaceutical drugs.”⁵⁵ In comparison, firearms caused 31,672 deaths and motor vehicle accidents caused 35,332 deaths that year.⁵⁶

2010: Statistics on Causes of Death in the U.S. ⁵⁷	
Cause of Death	Number of Deaths
Total Drug Overdoses	38,329
Pharmaceutical Drug Overdoses	22,134
Illicit Drug Overdoses	16,195
Car Crashes	35,332
Firearms	31,672

Many of these individuals have SUDs. SUDs are comparable to other chronic medical conditions, like hypertension and asthma, in terms of heritability, etiology, pathophysiology, and response to treatment.⁵⁸

52. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2010 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS (2011), available at <http://www.samhsa.gov/data/nsduh/2k10nsduh/2k10results.htm>.

53. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., THE DAWN REPORT: HIGHLIGHTS OF THE 2009 DRUG ABUSE WARNING NETWORK (DAWN) FINDINGS ON DRUG-RELATED EMERGENCY DEPARTMENT VISITS (2010), available at <http://www.oas.samhsa.gov/2k10/DAWN034/EDHighlights.htm>.

54. Press Release, Ctrs. for Disease Control & Prevention, *supra* note 51.

55. *Id.*; *What are Opioids?*, NAT'L INST. ON DRUG ABUSE, <http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids> (last visited Mar. 20, 2014); see also Stewart B. Leavitt, *Drug Overdose Deaths Still Rising in U.S.*, PAIN TREATMENT TOPICS (Feb. 19, 2013), <http://updates.pain-topics.org/2013/02/drug-overdose-deaths-still-rising-in-us.html> (stating that of those 16,651 deaths involving opioids, 4903 were the result of opioid use alone and the rest of the deaths involved a combination of opioids and alcohol, other prescription medications, or illicit drugs).

56. Sherry L. Murphy et al., *Deaths: Final Data for 2010*, NAT'L CENTER FOR HEALTH STAT. NAT'L VITAL STAT. REP., May 8, 2013, at 1, 40–41, available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf.

57. Murphy et al., *supra* note 56, at 40–41; Press Release, Ctrs. for Disease Control & Prevention, *supra* note 51.

58. Shelly F. Greenfield et al., *Treatment for Substance Use Disorders in a Privately Insured Population Under Managed Care: Costs and Services Use*, 27 J. SUBSTANCE ABUSE TREATMENT 265 (2004). “[H]eritability is defined as the amount of variability within a group that can be explained by genetic differences.” Helen C. Harton & Martin J. Bourgeois, *Cultural Elements Emerge from Dynamic Social Impact*, in THE PSYCHOLOGICAL FOUNDATIONS OF CULTURE 41, 57 (Mark Schaller & Christian S. Crandall eds., 2004). Etiology is a “branch

Effective treatments are available for SUDs. For instance, medication-assisted treatment (MAT) is used to treat opioid use disorders. MAT refers to “any treatment for [an SUD] that includes a medication . . . approved by the U.S. Food and Drug Administration (FDA)” as part of a comprehensive treatment plan.⁵⁹ An ultimate goal of MAT is patient recovery and full social function.⁶⁰ Recent studies show that SUD treatments, such as MAT, result in substantial benefits, including reduction in illicit substance use,⁶¹ improved psychiatric status, greater social adjustment, increased functional state and quality of life, decreased costs of hospital and emergency room services, reduced likelihood of overdose and death, and lower criminality.⁶² Neverthe-

of medicine which deals with the causes or origins of disease.” IAN HACKING, *REWRITING THE SOUL: MULTIPLE PERSONALITY AND THE SCIENCE OF MEMORY* 81 (1995). Pathophysiology is defined as “the physiology of disordered function.” Raymond Blessey, *Epidemiology, Risk Factors, and Pathophysiology of Ischemic Heart Disease*, 65 *PHYSICAL THERAPY* 1796, 1800 (1985) (quoting *DORLAND’S ILLUSTRATED MEDICAL DICTIONARY* (26th ed. 1981)).

59. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS: A TREATMENT IMPROVEMENT PROTOCOL: TIP 43*, at 2 (2005), available at http://www.asam.org/docs/advocacy/samhsa_tip43_matforopioidaddiction.pdf?sfvrsn=0.

60. *Pharmacotherapy for Substance Use Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., <http://dpt.samhsa.gov/medications/medsindex.aspx> (last visited Mar. 20, 2014).

61. As used herein, the term “substance use” includes the consumption of an illicit substance or an analog thereof, prescription medication misuse and abuse, and alcohol abuse. It excludes taking medications as prescribed by a physician. Analogs, or designer drugs, are substances composed of the “compounds that produce the ‘high’ or euphoria of controlled substances, . . . but that are chemically different.” *Designer Drugs: The Analog Game*, NARCOTIC EDUC. FOUND. AM., <https://www.cnoa.org/documents/NDESIGNER.pdf> (last visited Mar. 20, 2014). They are typically manufactured in order to avoid governance by the Controlled Substances Act, *Id.*; however, the Federal Analog Act, a 1986 amendment to the Controlled Substances Act, states that any chemical “substantially similar” to a controlled substance listed in Schedule I or II will be treated as if it were also listed in those schedules, but only if intended for human consumption. 21 U.S.C. § 813 (2013). Often, analog drugs, such as “bath salts,” will have names that imply they are not intended to be consumed or will be labeled with “not intended for human consumption” in attempts to mask their intended purpose. “Prescription medication misuse” is the use of a medication for a medical purpose other than as directed or indicated, whether willful or unintentional, and whether harm results or not. “Prescription medication abuse” is the intentional self-administration of a medication for a nonmedical purpose, such as “getting high.” Katz et al., *supra* note 50, at 648.

62. *E.g.*, John R.M. Caplehorn et al., *Retention in Methadone Maintenance and Heroin Addicts’ Risk of Death*, 89 *ADDICTION* 203 (1994); Shane Darke & Deborah Zador, *Fatal Heroin “Overdose”: A Review*, 91 *ADDICTION* 1765 (1996); Marina Davoli et al., *Risk Factors for Overdose Mortality: A Case-Control Study Within a Cohort of Intravenous Drug Users*, 22 *INT’L J. EPIDEMIOLOGY* 273 (1993); Greenfield et al., *supra* note 57; L. Grönbladh et al., *Mortality in Heroin Addiction: Impact of Methadone Treatment*, 82 *ACTA PSYCHIATRICA SCANDINAVICA* 223 (1990); G.K. Hulse et al., *The Quantification of Mortality Resulting from the Regular Use of Illicit Opiates*, 94 *ADDICTION* 221 (1999); Mary Jeanne Kreek & Frank J. Vocci, *History and Current Status of Opioid Maintenance Treatments: Blending Conference Session*, 23 *J. SUBSTANCE ABUSE TREATMENT* 93 (2002); Miranda W.

less, access to such treatment has been historically limited due to stigma and cost.⁶³

C. Trend Toward Viewing Treatment as More Socially Acceptable

Recent trends establish that access to SUD treatment is slowly expanding. The American Medical Association (AMA) first identified alcoholism as a disease in 1956.⁶⁴ In 1987, more than thirty years later, the AMA formally added drug addiction to this classification.⁶⁵ In 1970, Congress passed the Controlled Substances Act (CSA), a federal law regulating, among other things, the prescribing and dispensing of controlled substances.⁶⁶ After the passage of the CSA, physicians were allowed, for the first time, to prescribe the opioid medication methadone for treatment of opioid addiction.⁶⁷ The Drug Addiction Treatment Act of 2000 (“DATA 2000”),⁶⁸ enacted on October 17, 2000, as an amendment to the CSA, aimed to expand access to SUD treatment by integrating opioid detoxification and maintenance treatment into office-based medical practices in the United States.⁶⁹

More recently, federal agencies have adopted policies supporting SUD treatment. For example, in the Obama Administration’s 2013 National Drug Control Strategy, the Office of National Drug Control Policy has stated that “addiction treatment must be an integrated, accessible part of mainstream

Langendam et al., *The Impact of Harm-Reduction-Based Methadone Treatment on Mortality Among Heroin Users*, 91 AM. J. PUB. HEALTH 774 (2001); Icro Maremmani et al., *Substance Use and Quality of Life Over 12 Months Among Buprenorphine Maintenance-Treated and Methadone Maintenance-Treated Heroin-Addicted Patients*, 33 J. SUBSTANCE ABUSE TREATMENT 91 (2007); T.V. Parran et al., *Long-Term Outcomes of Office-Based Buprenorphine/Naloxone Maintenance Therapy*, 106 DRUG & ALCOHOL DEPENDENCE 56 (2010); Russell K. Portenoy & Kathleen M. Foley, *Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases*, 25 PAIN 171 (1986); D. Dwayne Simpson et al., *Drug Abuse Treatment Retention and Process Effects on Follow-Up Outcomes*, 47 DRUG & ALCOHOL DEPENDENCE 227 (1997).

63. Miller & Swift, *supra* note 17, at 408–09; Schwartz, *supra* note 25.

64. Ken Roy & Michael Miller, *Parity and the Medicalization of Addiction Treatment*, 42 J. PSYCHOACTIVE DRUGS 115, 116 (2010).

65. *Id.*

66. Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (codified as amended at 21 U.S.C. §§ 801–852 (2011)).

67. *Id.* §§ 202, 309. Opioids are a class of controlled substances that are typically prescribed to treat pain. NAT’L INST. ON DRUG ABUSE, PRESCRIPTION DRUG ABUSE 2 (2011), available at <http://www.drugabuse.gov/sites/default/files/rxreportfinalprint.pdf>. Opioids reduce the intensity of pain signals that reach the brain and affect areas of the brain that control emotion, which diminishes the effects of a painful stimulus. *Id.* Medications that fall within this class include hydrocodone, oxycodone, morphine, and codeine. *Id.*

68. 21 U.S.C. § 823(g)(2) (2012); Drug Addiction Treatment Act of 2000, Pub. L. No. 106-310, tit. XXXV, 114 Stat. 1101, 1222–27.

69. *See id.*

health care.”⁷⁰ The National Institute on Drug Abuse has taken the position that substance use treatment must be readily available, stating that “[p]otential patients can be lost if treatment is not immediately available or readily accessible.”⁷¹ In addition to the CSA, DATA 2000, and federal policies, two major laws were enacted to expand consumer access to SUD treatment in the past two decades: the Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act.

D. Legal Parity Requirements

1. *The Mental Health Parity Act of 1996*

In 1992, a National Advisory Mental Health Council report found that mental illnesses are not only treatable but that treatments are cost-effective.⁷² Congress enacted the Mental Health Parity Act of 1996 (MHPA) in an attempt to expand access to care.⁷³ It offered partial parity by prohibiting only group health plans⁷⁴ that already offered mental health coverage from imposing annual and lifetime dollar limits that were greater than the limits imposed on coverage of physical illness.⁷⁵ However, the MHPA was limited in scope and did “not compel insurers to provide mental health coverage.”⁷⁶ It also offered an exemption for employers with fifty or fewer employees.⁷⁷ Moreover, the MHPA did not include coverage for SUD treatment, even though statistics show that “roughly fifty percent of individuals with severe mental disorders are affected by [SUDs] . . . and fifty-three percent of [people with SUDs] also have at least one serious mental illness.”⁷⁸

70. OFFICE OF NAT’L DRUG CONTROL POLICY, NATIONAL DRUG CONTROL STRATEGY 20 (2013), available at http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs_2013.pdf.

71. NAT’L INST. ON DRUG ABUSE, *supra* note 26, at 2.

72. RAMYA SUNDARARAMAN & C. STEPHEN REDHEAD, CONG. RESEARCH SERV., RL33820, THE MENTAL HEALTH PARITY ACT: A LEGISLATIVE HISTORY 2 (2008), available at http://www.house.gov/sites/members/nc04_price/issues/uploadedfiles/health3.pdf.

73. Mental Health Parity Act of 1996, Pub. L. No. 104-204, tit. VII, 110 Stat. 2874, 2944–51; SUNDARARAMAN & REDHEAD, *supra* note 72, at 1.

74. A group health plan is a plan, including an insured or a self-insured plan, of an employer or contributed to by an employer or employee organization to provide health care to employees, former employees, others associated or formerly associated with the employer in a business relationship, or their families, directly or through insurance, reimbursement or otherwise. See 26 U.S.C. § 5000(b)(1) (2012); 42 U.S.C. § 300gg-91(a)(1) (2012).

75. SUNDARARAMAN & REDHEAD, *supra* note 72, at 1. Aside from dollar limitations, the MHPA did not prohibit any other forms of discrimination. *Id.*

76. *Id.*

77. *Id.* at 8.

78. Sara Nadim, *The 2008 Mental Health Parity and Addiction Equity Act: An Overview of the New Legislation and Why an Amendment Should Be Passed to Specifically Define Mental Illness and Substance Use Disorders*, 16 CONN. INS. L.J. 297, 303–04 (2009).

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

The MHPA expired in 2007,⁷⁹ and in 2008, President Bush signed the more comprehensive Mental Health Parity and Addiction Equity Act into law as amendments to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC).⁸⁰ The Equity Act filled in some of the gaps that the MHPA left open. For instance, it explicitly extended coverage to include SUD benefits.⁸¹ In particular, if group health plans offered medical and surgical benefits as well as mental health or substance use disorder (MH/SUD) benefits, then financial requirements and treatment limitations applicable to such MH/SUD benefits must be “no more restrictive” than the predominant financial requirements and treatment limitations placed on “substantially all medical and surgical benefits covered by the plan.”⁸² Financial requirements include “deductibles, copayments, coinsurance, and out-of-pocket expenses.”⁸³ Treatment limitations include “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.”⁸⁴

The Equity Act provided additional improvements over the MHPA. For instance, it limited cost-sharing, stating that there must be no separate cost-sharing requirements or treatment limitations that are applicable only to MH/SUD benefits.⁸⁵ Moreover, it requires health plans that provide out-of-network coverage for medical and surgical benefits to also provide equal out-of-network coverage for MH/SUD benefits.⁸⁶ Additionally, the Equity Act expanded parity to benefits in Medicaid MCO plans to an extent, as discussed below.⁸⁷

79. See SUNDARARAMAN & REDHEAD, *supra* note 72, at 10–11.

80. See 29 U.S.C. § 1185a (2012); Nadim, *supra* note 78, at 306; see also Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Title V(B), 122 Stat. 3765, 3881–93.

81. See 29 U.S.C. § 1185a(a)(1).

82. *Id.* § 1185a(a)(3)(A).

83. *Id.* § 1185a(a)(3)(B)(i).

84. *Id.* § 1185a(a)(3)(B)(iii).

85. *Id.* § 1185a(a)(3)(A). Cost sharing, or the share of costs between the patient and the insurer, includes patients’ out-of-pocket expenditures on deductibles, copayments, coinsurance, direct expenditures for health care services, equipment, and supplies, and anything else that is not covered by insurance, excluding premiums. Paul W. Newacheck & Sue E. Kim, *A National Profile of Health Care Utilization and Expenditures for Children with Special Health Care Needs*, 159 ARCHIVES PEDIATRICS & ADOLESCENT MED. 10, 11 (2005), available at <http://archpedi.jamanetwork.com/article.aspx?articleid=485899>.

86. 29 U.S.C. § 1185a(a)(5).

87. 42 U.S.C. § 1396u-2(b)(8) (2012); CINDY MANN, CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 41, at 2; *infra* Part III.A.4.

Despite its improvements, the Equity Act also has disconcerting limitations. For instance, it does not mandate coverage of MH/SUD benefits; only plans that choose to offer coverage of MH/SUDs must offer equivalent coverage.⁸⁸ The Equity Act also does not apply to small-employer plans, defined as those with fifty or fewer employees, nor does it apply to individual plans.⁸⁹ Additionally, it provides a cost exemption: if a plan or issuer makes changes in order to comply with the Equity Act and incurs an increased cost of at least 2% in the first year that the Equity Act applies or incurs an increased cost of at least 1% in any subsequent plan year, then a plan or issuer may claim an exemption from the requirements of the Equity Act based on its increased costs.⁹⁰ A plan or issuer is exempt from the Equity Act's requirements for the plan or policy year following the year the cost was incurred.⁹¹

3. *The Equity Act Regulations*

The Centers for Medicare & Medicaid Services (CMS), the Internal Revenue Service (IRS), and the Employee Benefits Security Administration of the Department of Labor (DOL) promulgated an interim final rule for the Equity Act on February 2, 2010 ("Interim Regulations").⁹² These Interim Regulations expanded the definition of treatment limitations to include both quantitative and non-quantitative treatment limitations (NQTLs).⁹³ Quantitative treatment limitations are defined as limitations that are "expressed numerically (such as 50 outpatient visits per year)."⁹⁴ They include "frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment."⁹⁵ NQTLs are de-

88. 29 U.S.C. § 1185a(b).

89. *Id.* § 1185a(c)(1)(A)–(B).

90. *Id.* § 1185a(c)(2)(A)–(B); *The Mental Health Parity and Addiction Equity Act*, CENTERS FOR MEDICARE & MEDICAID SERVICES, http://cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (last visited Mar. 21, 2014).

91. 29 U.S.C. § 1185a(c)(2)(A). "The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last one year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least one percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year." *The Mental Health Parity and Addiction Equity Act*, *supra* note 89.

92. 29 C.F.R. § 2590.712 (2013); *Interim Final Rules to Implement the Mental Health Parity and Addiction Equity Act of 2008 Go into Effect on April 5, 2010*, CENTER FOR MEDICARE ADVOC., <http://www.medicareadvocacy.org/interim-final-rules-to-implement-the-mental-health-parity-and-addiction-equity-act-of-2008-go-into-effect-on-april-5-2010/> (last visited Mar. 21, 2014).

93. 29 C.F.R. § 2590.712(a).

94. *Id.*

95. *Id.*

defined as limitations that are not expressed numerically, but “otherwise limit the scope or duration of benefits for treatment.”⁹⁶ The Interim Regulations provided a list of examples of methods that may be considered NQTLs, such as standards for determining medical necessity; preauthorization requirements; formulary design; “refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)”;

network standards for provider reimbursement; and “exclusions based on failure to complete a course of treatment.”⁹⁷ The Interim Regulations stated:

A group health plan . . . that provides both medical/surgical benefits and [MH/SUD] benefits may not apply any financial requirement or treatment limitation to [MH/SUD] benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.⁹⁸

The classifications for which the Interim Regulations applied were explicitly limited to inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.⁹⁹ Financial or quantitative treatment limitations are applied to “substantially all medical/surgical benefits in a classification of benefits if [the limitation] applies to at least two-thirds of all medical/surgical benefits in that classification.”¹⁰⁰ The level of the financial or quantitative treatment limitation is considered “predominant” if the level “applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitations.”¹⁰¹

The Interim Regulations used a different test to measure a violation of NQTL standards (“Comparable Test”) than they used for a violation of quantitative treatment limitation standards:

A group health plan . . . may not impose a[n NQTL] with respect to [MH/SUD] benefits in any classification unless, under the terms of the plan . . . as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the [NQTL] to [MH/SUD] benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in

96. *Id.* § 2590.712(a), (c)(4)(ii).

97. *Id.*

98. *Id.* § 2590.712(c)(2)(i).

99. 29 C.F.R. § 2590.712(c)(2)(ii)(A).

100. *Id.* § 2590.712(c)(3)(i)(A).

101. *Id.* § 2590.712(c)(3)(i)(B)(1).

applying the limitation with respect to medical surgical/benefits in the classification.”¹⁰²

Although the term “comparable” was not defined, the Interim Regulations provided some examples of processes used in applying NQTLs that are “not comparable.”¹⁰³ For instance, a concurrent review process, which is the “review or authorization for procedures or services during the time such services are being rendered,” is not comparable to the retrospective review process, which is the “review of services after they have been rendered.”¹⁰⁴

The Interim Regulations also included disclosure requirements.¹⁰⁵ For example, insurers must make available upon request the criteria for medical necessity determinations¹⁰⁶ regarding MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider.¹⁰⁷ Insurers must also provide the reason for any denial of reimbursement or payment for MH/SUD services within a reasonable timeframe to participants and beneficiaries upon request.¹⁰⁸

Despite their improvements in clarifying some of the ambiguities of the Equity Act, the Interim Regulations created some troubling ambiguities and loopholes. For instance, the Interim Regulations did not define the scope of services or continuum of care for beneficiaries of MH/SUD services.¹⁰⁹ “Scope of services generally refers to the types of treatment and treatment settings that are covered by a [health insurance plan].”¹¹⁰ Instead of enumer-

102. *Id.* § 2590.712(c)(4)(i).

103. *Id.* § 2950.712(c)(4)(iii).

104. *Id.* § 2590.712(c)(4)(iii) (Example 1); Janet Lerman, *Medical Practice Strategies: Systems Based Practice - Business Laws Ethics, Utilization Review - Class 5*, MEDICAL PRACTICE CME.COM, <http://www.medicalpracticecme.com/Class%205/Articles%20for%20class%205/article%201%20class%205.htm> (last visited Mar. 21, 2014).

105. 29 C.F.R. § 2590.712(d).

106. Access to health services in private, federal, and state health insurance plans can depend in part on whether the service provided is considered a medical necessity. Morris A. Landau, *The Difficulties in Defining Medical Necessity*, U. HOUS. L. CENTER (Nov. 29, 2000), <http://www.law.uh.edu/healthlaw/perspectives/Managed/001129Difficulties.html>. In general terms, “medical necessity” refers to the legal authority of a managed care organization, a Medicaid agency, or other purchaser of health care to determine whether a specific service will be covered in a specific situation. *Id.* The particular definition of “medical necessity” varies depending upon whether providers, physicians, courts, government insurers, private insurers, or consumers are using the term. *Id.*

107. 29 C.F.R. § 2590.712(d)(1).

108. *Id.* § 2590.712(d)(2)(a)(4).

109. *Id.* § 2590.712 ; AHP HEALTHCARE SOLUTIONS, SPECIAL REPORT: MHPAEA REGULATIONS, PRELIMINARY OPERATIONAL ANALYSIS OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT INTERIM FINAL RULE 6 (2010), available at <http://www.ahpnet.com/communications/documents/EquityActIFRAnalysisMarch2010LAC.aspx>.

110. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).

ating which types of treatment and treatment settings should be covered, the Interim Regulations stated that group health plans could define which services were covered in MH/SUD benefit packages, so long as those definitions were consistent with “generally recognized independent standards of current medical practice.”¹¹¹ By way of example of “generally recognized independent standards,” the Interim Regulations stated that current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the International Classification of Diseases (ICD), or state guidelines could be used in defining covered services; but the Interim Regulations also made it clear that other standards could be used.¹¹² Moreover, parity with non-MH/SUD benefit packages was limited to only six classifications.¹¹³ Like scope of services standards, these six classifications were not defined and were left to health plans and state health insurance laws to define.¹¹⁴

Furthermore, while the “substantially all/predominant” test was used for financial and quantitative limitations, there was no threshold test for NQTLs.¹¹⁵ Instead, the Comparable Test was used to determine whether processes, strategies, evidentiary standards, and other factors, as applied to MH/SUD benefits, were in fact NQTLs.¹¹⁶ However, this test was problematic because, as the Interim Regulations acknowledged, there may be different clinical standards used for medical/surgical benefits that are incomparable to those used for MH/SUD benefits.¹¹⁷ For example, as a result, insurers often covered skilled nursing facilities for medical/surgical care but excluded residential treatment for MH/SUD care—arguing that such benefits are not comparable because residential care does not require a nursing staff.¹¹⁸

In attempts to clear up ambiguities and close loopholes, the IRS, DOL, and the U.S. Department of Health and Human Services (HHS) issued Final Rules for the Equity Act (“Final Regulations” or “Final Rule”) on November 13, 2013, which apply to both grandfathered and non-grandfathered health plans.¹¹⁹ In addition to the six prior classifications of care for which

111. 29 C.F.R. § 2590.712(a) (2013); AHP HEALTHCARE SOLUTIONS, *supra* note 108, at 6.

112. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68242; 29 C.F.R. § 2590.712(a).

113. 29 C.F.R. § 2590.712(c)(2)(ii)(A); AHP HEALTHCARE SOLUTIONS, *supra* note 109, at 6.

114. 29 C.F.R. § 2590.712(c)(2)(ii)(A); AHP HEALTHCARE SOLUTIONS, *supra* note 109, at 6.

115. 29 C.F.R. § 2590.712(c)(3)–(4).

116. *Id.* § 2590.712(c)(4).

117. *Id.* § 2590.712(c)(4)(iii) (Example 4); AHP HEALTHCARE SOLUTIONS, *supra* note 109, at 7.

118. *See, e.g.,* Harlick v. Blue Shield of Cal., 686 F.3d 699, 703–06 (9th Cir. 2012).

119. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68240–41 & n.2 (Nov. 13, 2013) (to be

parity must be achieved under the Equity Act,¹²⁰ the Final Regulations created two sub-classifications for SUD care that must also receive parity: “[o]ffice visits (such as physician visits), and [a]ll other outpatient items and services [separate from office visits] (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).”¹²¹ They stated that these “classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and [MH/SUD] benefits offered by health plans and issuers;” thereby making it clear that MH/SUD services have to be comparable to the range and types of services for medical/surgical treatment within each class.¹²² Furthermore, it clarified that if a plan provides coverage for one classification, it must provide coverage for all classifications and sub-classifications.¹²³ However, plans that offer MH/SUD benefits do not have to provide coverage for all disorders and disabilities; for example, a plan could offer coverage for alcohol dependence but not drug dependence.¹²⁴

Additionally, although the Final Regulations do not define the scope of care that plans must offer, they do state that plans must offer intermediate care, including partial hospitalization, residential care, office visits and all other outpatient services, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items, in parity with such care offered for medical/surgical needs.¹²⁵ Furthermore, the Final Regulations stated that plans and issuers can look at an array of factors in determining reimbursement rates for the scope of services, such as service types, geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience, and licensure of providers; but all of these factors must be applied to MH/SUD services compa-

codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147). The rules apply to plan years beginning on or after July 1, 2014. *Id.*

120. These classifications include inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. 29 C.F.R. § 2590.712(c)(2)(ii)(A) (2013).

121. 45 C.F.R. § 146.136(c)(3)(iii)(C) (2013).

122. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68243; *Mental Health Parity and Addiction Equity Act*, AM. SOC’Y ADDICTION MED., <http://www.asam.org/advocacy/parity> (last visited Mar. 21, 2014).

123. 45 C.F.R. § 146.136(c)(2)(ii)(A).

124. However, as described below, a plan may still be required to cover additional substance use disorder treatment under the ACA. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68246–47.

125. 45 C.F.R. § 146.136(c)(3)(iii)(C); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68246.

rably and no more stringently than they are applied to medical/surgical services.¹²⁶

Additionally, the Final Rule acknowledged that insurers frequently abused the exception that allowed them to place discriminatory NQTLs on MH/SUD treatment based on a “recognized clinically appropriate standard of care”—thereby using this exception to deny coverage.¹²⁷ As such, the Final Rule removed this exception.¹²⁸ It clarified that plans and issuers would still “have the flexibility . . . to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/surgical benefits and [MH/SUD benefits],” as long as they apply the Comparable Test in doing so.¹²⁹

Moreover, many plans attempted to place NQTLs on MH/SUD benefits, arguing that such NQTLs were permitted as long as they were not specifically mentioned in the Interim Regulations’ list of NQTL examples.¹³⁰ As a result, the Final Regulations clearly stated that the list of specific NQTLs was an illustrative list and that all NQTLs, even if not named specifically, are regulated, including “prior authorization and concurrent review, service coding, provider network criteria, policy coverage conditions, and both in- and out-of-network geographical limitations.”¹³¹

However, just like the Interim Regulations, the Final Regulations also created some ambiguities and did not resolve all problems. For instance, the Interim Regulations did not address the scope of services that must be covered within specific classifications, allowing insurers to refuse to offer intermediate services, such as residential care.¹³² The Final Regulations continued to refuse to name specific services that must achieve parity. Instead, the Final Regulations deferred to states to define the package of insurance benefits that must be provided as essential health benefits.¹³³ The Final Rule did note that intermediate care must be covered, including MH/SUD residential care if the plan offered skilled nursing facilities or rehabilitation hospitals as inpatient medical/surgical benefits; in addition, the Final Rule required intensive outpatient MH/SUD services and partial hospitalization as outpatient services if a plan treated home health care as a medical/surgical

126. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68246.

127. *Id.* at 68245.

128. *Id.*

129. *Id.*

130. *See Id.* at 68245–46.

131. *Id.* at 68246.

132. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68246.

133. *Id.*

outpatient benefit.¹³⁴ Lastly, instead of creating a quantitative formula for applying NQTLs, the Final Regulations kept the Comparable Test for NQTLs without defining the term “comparable and no more stringently.”¹³⁵

4. *State Parity Laws*

State legislators began enacting some form of parity legislation twenty years before the MHPA was enacted,¹³⁶ and as of 2012, forty-nine states and the District of Columbia had enacted some form of parity laws.¹³⁷ The Equity Act continues to protect states’ rights to enact their own parity laws as long as they are equal to or more stringent than the requirements under the federal law.¹³⁸ Most states have implemented one of three parity requirements: voluntary participation, minimum coverage, and mandatory and equivalent coverage.¹³⁹ Voluntary participation does not require benefits to be provided at all.¹⁴⁰ Instead, it either requires the insurer to provide optional coverage for MH/SUD, or it can require that if MH/SUD benefits are offered, then they must be equal to medical/surgical benefits.¹⁴¹ For instance, the Equity Act is a voluntary participation statute because it does not require large group health plans to offer MH/SUD benefits, but if they choose to do so, then they must offer parity between MH/SUD benefits and medical/surgical benefits.

Minimum coverage requires insurers to provide some level of coverage for mental illnesses, SUDs, or some combination thereof.¹⁴² This is an intermediate parity requirement because it allows for discrepancies in the level of MH/SUD benefits as compared to medical/surgical benefits.¹⁴³ These

134. *Id.* at 68247.

135. *See id.* at 68244–45.

136. GAIL K. ROBINSON ET AL., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., STATE MANDATES FOR TREATMENT OF MENTAL ILLNESS AND SUBSTANCE USE DISORDERS 6–8 (2007), available at <http://store.samhsa.gov/shin/content//SMA07-4228/SMA07-4228-A.pdf>.

137. *See* ECRI Inst., *Mental Health Parity Laws and Their Impact on Insurance Benefits*, BULIMIA NERVOSA RESOURCE GUIDE, http://www.bulimiaguide.org/summary/detail.aspx?doc_id=9470 (last visited Mar. 21, 2014); NAT’L ALLIANCE ON MENTAL ILLNESS, STATE MENTAL HEALTH PARITY LAWS 2–15 (2009), available at http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Parity1/State_Parity_Chart_0709.pdf. Wyoming was the only state that lacked a parity law by 2012. *Id.*

138. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68252.

139. *See* ROBINSON ET AL., *supra* note 135, at 1; *see also State Laws Mandating or Regulating Mental Health Benefits*, NAT’L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> (last updated Jan. 2014).

140. *State Laws Mandating or Regulating Mental Health Benefits*, *supra* note 138.

141. *Id.*

142. ROBINSON ET AL., *supra* note 136, at 1.

143. *State Laws Mandating or Regulating Mental Health Benefits*, *supra* note 139.

discrepancies may include “different visit limits, copayments, deductibles, and annual and lifetime limits.”¹⁴⁴

Mandatory and equivalent coverage is the most stringent level of parity because it requires coverage of mental illnesses, SUDs, or a combination of the two, and it prohibits insurers from discriminating between coverage by requiring insurers to provide the same level of MH/SUD benefits as medical/surgical benefits.¹⁴⁵ For example, Vermont, which is a mandatory and equivalent coverage state, requires comprehensive parity without exclusions, stating that “[a] health insurance plan shall provide coverage for treatment of a mental [health] condition.”¹⁴⁶ Substance use is included in Vermont’s definition of “mental [health] condition.”¹⁴⁷

While thirty-two states require either mandatory and equivalent coverage or minimum coverage, only twenty-nine states require coverage of SUDs.¹⁴⁸ In 2003, small employers started claiming “that the steady rise in insurance costs was preventing them from offering additional coverage” and “that a contributing factor was the increasing number of required benefits.”¹⁴⁹ In response, state lawmakers “began . . . enacting legislation that waived or provided exemptions from [s]tate [parity] mandates” so insurers could offer reduced or “bare-bones” health insurance policies.¹⁵⁰ Some states have placed certain restrictions on, or granted exemptions to, the voluntary participation requirements, such as waiving the mandate for small employers or waiving the mandate if premium cost would increase once the benefit is added.¹⁵¹ For example, in Utah, small employer insurance providers must provide SUD benefits, but coverage “may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, before reach-

144. *Id.*

145. *Id.*

146. VT. STAT. ANN. tit. 8, § 4089b(c) (2012). The statute further states:

A health insurance plan shall provide coverage for treatment of a mental condition and shall: (1) not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental condition than for access to treatment for other health conditions . . . ; (2) not exclude from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer; and (3) make any deductible or out-of-pocket limits required under a health insurance plan comprehensive for coverage of both mental and physical health conditions.

Id.

147. *Id.* § 4089b(b)(2).

148. ROBINSON ET AL., *supra* note 136, at 41.

149. *Id.* at 8.

150. *Id.*

151. *Id.* at 40.

ing a maximum out-of-pocket limit.”¹⁵² In these states, more comprehensive insurance parity laws are needed.¹⁵³

E. The Affordable Care Act Expands Health Coverage

On March 23, 2010, the ACA was signed into law,¹⁵⁴ and as a result, approximately 24 million individuals, including 6 million individuals with mental health disorders or SUDs, are expected to gain health insurance coverage by 2016.¹⁵⁵ The legislation seeks to achieve this goal in five broad ways: (1) by providing citizens with subsidies to pay premiums and out-of-pocket expenses, (2) by expanding state Medicaid programs, (3) by prohibiting discrimination based on age or medical condition, (4) by instituting an individual mandate, and (5) by instituting employer mandates and financial incentives for employers to provide health insurance to their employees.¹⁵⁶ The individual mandate requires virtually all U.S. citizens and legal residents to obtain minimum essential health insurance coverage or pay a financial penalty for noncompliance.¹⁵⁷ As of January 1, 2014, individuals and qualified employers may purchase health insurance through American Health Benefit Exchanges (“Exchanges”).¹⁵⁸ The employer mandate requires

152. UTAH CODE ANN. § 31A-22-625(1)(a)(ii), (3)(b) (West 2012).

153. See *infra* Part III.B.2.

154. Ryan Sugden, Note, *Sick and (Still) Broke: Why the Affordable Care Act Won't End Medical Bankruptcy*, 38 WASH. U. J.L. & POL'Y 441, 456–57 (2012).

155. See *The Uninsured and the Difference Health Insurance Makes*, HENRY J. KAISER FAM. FOUND. (Sept. 1, 2012), <http://kff.org/health-reform/fact-sheet/the-uninsured-and-the-difference-health-insurance/>. Prior to the ACA there were approximately 47.9 uninsured individuals in the United States. *Id.* 25% of uninsured individuals have a mental health condition or substance use disorder. Kristen Boronio et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, U.S. DEP'T OF HEALTH AND HUMAN SERVS. OFFICE OF THE ASSISTANT SECRETARY OF PLANNING AND EVALUATION (Feb. 20, 2013), http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm. By 2016, the number of uninsured individuals is expected to decrease by half. *The Uninsured and the Difference Health Insurance Makes*, (2012).

156. Sugden, *supra* note 154, at 442, 458; *The Uninsured and the Difference Health Insurance Makes*, *supra* note 155.

157. 26 U.S.C. § 5000A(a), (c)–(d) (2012). Individuals will be required to pay the greater of a fixed amount or a percentage of income. *Id.* § 5000A(c)(2). The fixed penalty is \$95 in 2014, and it increases to \$695 by 2016. *Id.* § 5000A(c)(3). The income-based penalty is 1% of income in 2014, and it increases to 2.5% by 2016. *Id.* § 5000A(c)(2)(B).

158. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,310 (Mar. 27, 2012) (to be codified at 45 C.F.R. pts. 155, 156 & 157); 42 U.S.C. § 18031(b) (2012). A qualified employer is defined as a small employer that elects to make all of its full-time employees eligible for one or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans. 42 U.S.C. § 18032(f)(2)(A) (2012). The term “qualified health plan” is defined below. See *infra* text accompanying notes 160–62.

large employers¹⁵⁹ to offer coverage to employees or pay a fee for each employee who receives a premium tax credit for opting into Exchanges.¹⁶⁰

When the ACA is fully implemented,¹⁶¹ it will expand access to health insurance coverage for SUDs by requiring some level of coverage for substance use benefits in small group plans, individual plans, Exchange plans, and Medicaid plans.¹⁶² Insurers that offer “non-grandfathered”¹⁶³ health insurance coverage in the individual or small group markets¹⁶⁴ are now required to offer “Essential Health Benefits” (EHBs),¹⁶⁵ including benefits for MH/SUDs.¹⁶⁶ The ACA builds on the Equity Act by making MH/SUD ser-

159. Although the ACA defines a large employer as one who “employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year,” a state may elect to treat businesses with fifty employees or less as small businesses until 2016. 42 U.S.C. § 18024(b)(1), (3) (2012); *The Mental Health Parity and Addiction Equity Act*, *supra* note 90.

160. 26 U.S.C. § 4980H(a) (2012). Exchanges are competitive marketplaces for health insurance provided by states or the federal government. 42 U.S.C. § 18031(b); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. at 18, 310.

161. Most of the major reforms contained in the ACA begin to take effect in January 2014, and gradually increase until about 2020. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029; Mary Agnes Carey & Jenny Gold, Henry J. Kaiser Family Found., *After the Election: A Consumer’s Guide to the Health Law*, BLACK AIDS INST., <https://www.blackaids.org/news-2012/1431-after-the-election-a-consumers-guide-to-the-health-law> (last visited Sept. 5, 2014).

162. 42 U.S.C. §§ 1396u-7(b)(2)(A), 18022(b)(1)(E) (2012); 45 C.F.R. § 156.115(a)(3) (2013); 45 C.F.R. § 146.136(c)(2)(i) (2013); Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,843–44 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155 & 156).

163. A grandfathered health plan is one that existed on March 23, 2010, and in which the employer or insurer has not made any significant changes to the plan’s benefits or how much members pay through premiums, copays, or deductibles. 45 C.F.R. § 147.140(a), (g) (2013).

164. “Small group market[s] [are] health insurance market[s] under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained . . . by a small employer.” 42 U.S.C. § 18024(a)(3). A small employer is one who has “employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.” *Id.* § 18024(b)(2).

165. 42 U.S.C. §§ 18022(a)–(b)(1), 18032(c)(1)–(2) (2012); 45 C.F.R. § 147.150(a) (2013).

166. 42 U.S.C. § 18022(b)(1)(E). EHBs include the following ten health care service categories that must be covered in non-grandfathered health insurance plans:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs

vices an EHB that must be covered in non-grandfathered health insurance plans.¹⁶⁷ The ACA directed the Secretary of HHS to ensure that EHBs are provided such that there is an appropriate balance between each type of benefit.¹⁶⁸ The Secretary determined that to offer adequate coverage of MH/SUD services as a category of EHBs, insurers must meet the same standards as in the Equity Act.¹⁶⁹

The ACA also requires that Exchanges offer qualified health plans (QHPs).¹⁷⁰ A QHP is, among other things, a certified health plan that provides EHBs, is offered by a licensed health insurance issuer, offers certain levels of quality coverage,¹⁷¹ and charges the same premium rate for plans offered through the Exchange as the rate for plans offered directly from the issuer.¹⁷² Given that plans on the Exchanges must offer QHPs, and QHPs must include coverage of EHBs, Exchange plans are consequently required to offer at least minimum coverage of substance use benefits.

The ACA explicitly expanded parity coverage under the Equity Act to ABPs.¹⁷³ The ACA amended the Social Security Act to now require that if a

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- Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care

Id. § 18022(b)(1).

167. *The Mental Health Parity and Addiction Equity Act*, *supra* note 89.

168. 42 U.S.C. § 18022(b)(4)(A).

169. 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).

170. 42 U.S.C. § 18031(d)(2) (2012).

171. The ACA's levels of coverage are designed to provide benefits that are actuarially equivalent to a certain percentage of the full actuarial value of the benefits provided under the plan. For instance, the Bronze Level provides benefits equivalent to 60%, the Silver Level provides benefits equivalent to 70%, the Gold Level provides benefits equivalent to 80%, and the Platinum Level provides benefits equivalent to 90% of the full actuarial value of benefits provided under the plan. 42 U.S.C. § 18022(d)(1).

172. 42 U.S.C. § 18021(a)(1) (2012).

173. *Id.* § 1396u-7(b)(5)–(6) (2012); *see* Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42,160, 42,160 (July 15, 2013) (to be codified at 42 C.F.R. pts. 431, 435, 436, 438, 440, 447 & 457; 45 C.F.R. pts. 155 & 156). "Benchmark" means that the benefits are at least equal to one of the four statutorily specified plans. The four benchmark plans are: (1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program ("FEHBP"); (2) State employee coverage that is offered and generally available to state employees ("State Employee Coverage"); (3) The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state ("Commercial HMO"); and (4) Secretary-approved coverage, which can include the Medicaid state plan-benefit package offered in that state. "Benchmark-equivalent" means that the benefits include certain specified services, and the overall benefits

Medicaid ABP, as distinguished from a Medicaid managed care plan, “provides both [medical/surgical and MH/SUD] benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of [the Equity Act] in the same manner as such requirements apply to a group health plan.”¹⁷⁴ Moreover, although the Final Rule of the Equity Act does not apply to ABPs, CMS guidance, which governs ABPs, requires ABPs to comply with the majority of the Final Rule.¹⁷⁵ CMS guidance states that all ABPs must comply with financial requirements, prohibitions on treatment limitations (both quantitative and non-quantitative), out-of-network coverage requirements, and availability of information regarding both medical necessity determinations and reasons for denial of reimbursement or payment for services.¹⁷⁶

Large employers are not required to offer EHBs to their employees. Instead, they must offer “minimum value” care (which is commonly referred to as “adequate” care) or risk facing a penalty if one of their employees receives a premium tax credit by opting to use the Exchange.¹⁷⁷ A plan fails to provide minimum value care if the plan’s share of the total allowed costs of benefits provided is less than sixty percent of the costs.¹⁷⁸

In sum, under the ACA, non-grandfathered small group plans, individual plans, Exchange plans, and Medicaid ABPs must offer SUD benefits, and such plans must offer parity between MH/SUD coverage and medical/surgical coverage.¹⁷⁹ Non-grandfathered small group plans and individual plans must offer EHBs.¹⁸⁰ Exchange plans and Medicaid ABPs must offer

are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages. CINDY MANN, *CTRS. FOR MEDICARE & MEDICAID SERVS.*, *supra* note 41, at 1–2.

174. 42 U.S.C. § 1396u-7(b)(6)(A).

175. CINDY MANN, *CTRS. FOR MEDICARE & MEDICAID SERVS.*, *supra* note 41, at 2.

176. *See id.* (“The Mental Health Parity and Addiction Equity Act (MHPAEA) applies to Alternatives Benefit.”).

177. 26 U.S.C. §§ 36B(c)(2)(C), 4980H(b)(1) (2012); Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25,909, 25,909 (proposed May 3, 2013) (to be codified at 26 C.F.R. pt. 1).

178. 26 U.S.C. § 36B(c)(2)(C)(ii). The “[p]ercentage of the total allowed costs” provided under a group health plan is defined as “[(1) the anticipated covered medical spending for EHB coverage . . . paid by a health plan for a standard population, [(2)] computed in accordance with the plan’s cost-sharing, [and (3)] divided by the total anticipated allowed charges for EHB coverage provided to a standard population.” 45 C.F.R. § 156.20 (2013). The standard population used for this computation “must reflect the population covered by [typical] self-insured group health plans.” 45 C.F.R. § 156.145(c) (2013). For the definition of “group health plan,” see *supra* Part I.D.1.

179. 42 U.S.C. § 18031(j) (2012).

180. FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation, U.S. DEPT OF LABOR <http://www.dol.gov/ebsa/faqs/faq-aca18.html#footnotes> (last updated Jan. 9, 2014).

QHPs,¹⁸¹ and, consequently, must offer EHBs as well.¹⁸² Under the ACA, all QHPs must comply with the Equity Act,¹⁸³ and both the ACA regulations and the Equity Act regulations explicitly state that all plans that offer EHBs must comply with the Equity Act regulations in order to satisfy the requirement to cover EHBs.¹⁸⁴ Therefore, although the Equity Act states that it applies only to large group plans, the ACA expanded federal parity to those plans offering EHBs: non-grandfathered small group plans, individual plans, Exchange plans, and Medicaid ABPs.¹⁸⁵

Such expansion partially closes one major loophole in the Equity Act by ensuring that certain plans must provide benefits for SUDs and such benefits must be administered in parity with those offered for medical/surgical treatment.¹⁸⁶ In doing so, using the categorical terminology of state parity laws, the ACA converted the Equity Act from a voluntary coverage law to a mandatory and equivalent coverage law for non-grandfathered small group plans, individual plans, Exchange plans, and Medicaid ABPs. And although large group plans and Medicaid MCO plans are not required to offer SUD benefits, if they voluntarily offer such benefits, they must still provide equitable coverage under the Equity Act.

II. COMMON RESTRICTIONS ON SUD TREATMENT

Even with the enactment of the Equity Act, its Final Regulations, the ACA, and state parity laws, many insurers still place significant obstacles in the way of SUD benefits. For instance, a recent report by the American Society of Addiction Medicine (ASAM) found that most state Medicaid plans and many private insurance policies place heavy restrictions on access to MAT and the medications used in MAT.¹⁸⁷ Many of these restrictions vio-

181. *Id.* § 18031(d)(2).

182. *See Id.* § 18021(a)(1)(B).

183. 42 U.S.C. § 18031(j).

184. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68240–41 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147); Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,844 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155 & 156).

185. 42 U.S.C. § 1396a(a)(10)(C)(iv) (2012); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68248. For a refresher on ABPs, please see *supra* Part II.A.2.

186. 45 C.F.R. § 156.115(a)(3) (2013).

187. Suzanne Gelber Rinaldo & David W. Rinaldo, The Avisa Group, *Availability Without Accessibility? State Medicaid Coverage and Authorization Requirements for Opioid Dependence Medications*, in *ADVANCING ACCESS TO ADDICTION MEDICATIONS: IMPLICATIONS FOR OPIOID ADDICTION TREATMENT* 6, 10–11 (Am. Soc’y of Addiction Med. ed., 2013),

late the Equity Act, its Final Regulations, and the ACA. This section discusses ways in which private insurers and state Medicaid programs have created barriers to access, and this section analyzes how such barriers are violations of the Equity Act and the ACA. Currently, most case law pertaining to parity deals with denials of MH benefits, so this section will draw parallels between those cases and denials of SUD treatment coverage.

A. Medical Necessity

Insurers have medical necessity guidelines, which are based on “generally accepted treatments that meet . . . community standards of care” and are used to determine whether to grant coverage of a particular service.¹⁸⁸ All too often, individuals are denied access to MH/SUD benefits because insurers implement their own vague medical necessity standards, leading to unequal coverage for treatment.¹⁸⁹

For instance, in *Arce v. Kaiser Foundation Health Plan, Inc.*,¹⁹⁰ the father of a four-year-old boy with autism filed a class action suit against the defendant insurer pursuant to California’s Mental Health Parity Act.¹⁹¹ The California Mental Health Parity Act is a minimum coverage plan because it obligates health plans to provide coverage for the diagnosis and treatment of mental illnesses.¹⁹² The plaintiffs alleged that the defendant denied coverage for certain therapies for autism spectrum disorders “on the grounds that the therapies are ‘non-health care services,’ ‘academic or educational interventions,’ or ‘custodial care’” rather than determining that those therapies were not medically necessary.¹⁹³ The Ninth Circuit held that the defendant could not categorically deny “coverage for mental health care services that may . . . be medically necessary” on the basis that the therapies are not “health care services”¹⁹⁴ without considering whether such services are, in fact, medically

available at <http://www.asam.org/docs/advocacy/Implications-for-Opioid-Addiction-Treatment>. For a refresher on MAT, please see *supra* Part II.B.

188. *Benefiting from Mental Health Parity*, HARV. MENTAL HEALTH LETTER, Jan. 2009, available at http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2009/January/Benefiting_from_mental_health_parity.

189. Letter from Representatives of the Cal. Coal. for Whole Health to Peter Lee, Exec. Dir., & Diana Dooley, Chair, Cal. Health Benefit Exch. 1 (Oct. 26, 2012), available at http://www.cmhda.org/go/portals/0/cmhda%20files/breaking%20news/1210_october/ccwh%20comments%20to%20hbex%20on%20consumer%20assistance%20program%2010-26-12.pdf.

190. 104 Cal. Rptr. 3d 545 (Cal. Ct. App. 2010).

191. *Id.* at 552–53.

192. CAL. HEALTH & SAFETY CODE § 1374.72(a) (West 2002).

193. *Arce*, 104 Cal. Rptr. 3d at 565.

194. Under California’s mental health parity laws, insurers are not required to cover routine patient care costs that are not health care services. CAL. INS. CODE § 1374.72 (West 2013). (discussing a federal district court finding that federal law preempted California’s

necessary for its individual plan members.¹⁹⁵ Therefore, if the reasoning of this case was extended to all state and federal plans, insurers offering minimum coverage and mandatory and equivalent coverage plans violate parity laws when they fail to inquire as to whether the care is medically necessary, and also when they wrongfully deny care that was medically necessary for MH/SUD diagnosis or treatment.¹⁹⁶

Moreover, had the facts of *Arce* occurred after the Equity Act Final Regulations were implemented, the plaintiffs could have argued under federal parity law that “[m]edical management standards limiting or excluding benefits based on medical necessity or medical appropriateness” are among the specified NQTLs in the Equity Act Regulations.¹⁹⁷ As a result, such standards must be comparable to and not more stringently applied than the standards used for medical/surgical benefits.¹⁹⁸

B. Prior Authorization

Although prior authorization is specifically listed as an NQTL, many private insurers and forty-four state Medicaid plans require complex authorizations before a patient can qualify for MAT benefits, and they require “reauthorization processes that become more demanding with each reauthorization period.”¹⁹⁹ Such authorization processes require extensive details.²⁰⁰ Documents that must be submitted as proof of prior authorization for MAT for opioid dependence “may take days or weeks while . . . patients risk relapse, overdose, and death.”²⁰¹ Additionally, many private and public insurers, including Medicaid, offer minimal coverage of counseling and yet require counseling as a prerequisite to preauthorization or reauthorization of MAT coverage, creating a catch-22.²⁰² Often, these plans do not require similar processes for medical/surgical care.²⁰³

Mental Health Parity Act) *Brazil v. Office of Pers. Mgmt.*, 2014 WL 1309935 (N.D. Cal. Mar. 28, 2014).

195. *Arce*, 104 Cal. Rptr. 3d at 565.

196. *Id.*; Megan Lagreca, Note, *Treating a Chronic Case of Discrimination: The Ninth Circuit’s Prescription for Mental Health Patients’ Rights in Harlick v. Blue Shield*, 58 VILL. L. REV. 269, 283 (2013).

197. 29 C.F.R. § 2590.712(c)(4)(ii)(A) (2013).

198. *Id.* § 2590.712(c)(4)(i).

199. Rinaldo & Rinaldo, *The Avisa Group*, *supra* note 186, at 10–11, 33. Only Missouri, New Mexico, Rhode Island, and Vermont did not explicitly require prior authorization. *Id.* at 33 map 6. In addition, no information was available from Connecticut, New Jersey, or Pennsylvania. *Id.*

200. *See id.* at 41–42.

201. *Id.* at 11.

202. *See id.* at 5, 10, 30–31.

203. *Id.* at 13.

Amy Thompkins, an individual suffering from a dissociative disorder and bulimia, was denied coverage by her health insurance company.²⁰⁴ The insurance company also imposed harsh prior authorization requirements.²⁰⁵ Thompkins originally brought suit under the Employment Retirement Income Security Act of 1974, however, in *Thompkins v. BC Life and Health Insurance Co.* the court found that California's parity laws applied.²⁰⁶ The defendant covered the plaintiff's inpatient treatment from May to August in 2004.²⁰⁷ However, in September, the defendant refused to cover any further inpatient treatment, and, as a result, the plaintiff left the treatment center.²⁰⁸ Shortly thereafter, she relapsed, was purging several times a day, and had stopped eating and drinking.²⁰⁹ Despite these facts, the defendant instructed the plaintiff to obtain prior authorization, and when authorization was sought, the defendant only granted a "Partial Hospital Program with concurrent review," based on a determination that additional treatment was not medically necessary.²¹⁰ The plaintiff brought suit to ensure continued entitlement to inpatient treatment.²¹¹ California's parity laws "requires health insurance policies to cover treatment for mental illness on the same terms and conditions applied to other medical conditions," and therefore, the court held that the plaintiff was entitled to such benefits because the defendant could not prove that the treatment was not medically necessary, and furthermore, such restrictions were not imposed on medical services.²¹²

Thompkins was decided in 2006, before the Equity Act Final Regulations were promulgated. If Amy Thompkins brought her case today in federal court, she would have an even stronger argument because prior authorization is an NQTL explicitly mentioned in the Final Regulations of the Equity Act.²¹³ Therefore, if such requirements are not imposed or are less stringently imposed on comparable medical/surgical benefits, then the plan violates the Equity Act. Furthermore, if such plan is a mandatory and equiva-

204. *Thompkins v. BC Life & Health Ins. Co.*, 414 F. Supp. 2d 953, 954–55 (C.D. Cal. 2006).

205. *See id.* at 956–57.

206. *Id.* at 954.

207. *Id.* at 955.

208. *See id.* at 955–57.

209. *Id.* at 957.

210. *Thompkins*, 414 F. Supp. 2d at 957.

211. *Id.* at 955.

212. *Id.* at 959–60 (citing CAL. INS. CODE § 10144.5(a)–(d) (West 2013)).

213. 29 C.F.R. § 2590.712(c)(4)(ii)(A), (iii) (2013). One of the Regulations' examples states that if a plan refuses to pay benefits until prior authorization is achieved for SUD services and yet offers only a twenty-five percent reduction in the benefits that plan would otherwise pay for medical/surgical treatment before obtaining prior authorization, for instance, the plan is in violation of the Equity Act Interim Regulations. *Id.* § 2590.712(c)(4)(iii) (Example 3).

lent coverage plan under the ACA, the plaintiff could argue that the plan violates the ACA as well.

C. Residential Treatment

Residential care is often required for SUD detoxification and maintenance programs. Prior to the enactment of the Final Regulations of the Equity Act, many insurers found ways to discriminate against those with SUDs and MH illnesses by denying residential care—claiming that such care is not considered inpatient or outpatient treatment.²¹⁴ However, courts still found that such treatment was medically necessary. For instance, in *Harlick v. Blue Shield of Cal.*,²¹⁵ the plaintiff, Jeanene Harlick, suffered from anorexia nervosa, sought treatment in residential care, and was denied coverage after her insurer claimed that it simply did not cover such services.²¹⁶ The court held that California’s Mental Health Parity Act required health plans to “provide coverage of all ‘medically necessary treatment’ for ‘severe mental illnesses’ under the same financial terms as those applied to physical illnesses,” including residential treatment.²¹⁷

The Equity Act’s Final Regulations solidified such coverage. Although the Final Regulations left it to insurers to define the scope of the terms for inpatient and outpatient treatment, the Final Regulations do specify that intermediate treatment, including residential care, must be offered if comparable intermediate treatment is offered for medical/surgical benefits.²¹⁸ The Regulations also prohibit “[m]edical management standards” that unfairly limit or exclude benefits based on medical necessity,²¹⁹ which is often the

214. Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE U. L. REV. 179, 224 (2013).

215. 686 F.3d 699 (9th Cir. 2012).

216. *Id.* at 703–05.

217. *Id.* at 719, 721. *But see* Daniel F. v. Blue Shield of Cal., No. C 09–2037 PJH, 2011 WL 830623, at *9 (N.D. Cal. Mar. 3, 2011) (concluding that, “in California, whether a specific plan offers residential treatment as a covered benefit is a matter of contract only,” and therefore, such coverage is not mandated by the state parity law); Douglas S. v. Altius Health Plans, Inc., No. 09-4130, slip op. at 11–13 (10th Cir. Nov. 5, 2010) (finding that an “exclusion” of residential treatment is not the same thing as a “limitation,” that parity is limited to the specified categories in the statute, and that the defendant was in compliance with the Utah parity law since it was not required to provide “across-the-board parity between treatment options for mental and physical health conditions”); Edgar v. MVP Health Plan, Inc., No. 1:09-cv-700 (GLS\DRH), slip op. at 5–6, 18–19 (N.D.N.Y. May 9, 2011) (stating that although the plan stated it would comply with the Equity Act, such language does not create an exception that “voids the Plan’s preclusion of coverage for ‘care in a residential treatment facility.’”).

218. 45 C.F.R. § 146.136(c)(2)(ii)(A) (2013); *Id.* § 146.136 (c)(4)(iii) (Example 9).

219. 29 C.F.R. § 2590.712(c)(4)(i)–(ii)(A).

reason insurers give for denying care, although not all medical necessity denials are wrongful. Wrongful denials of coverage violate the Equity Act when limitations are not similarly applied or are applied less stringently in the case of comparable medical/surgical services. When this happens and the plan is a mandatory and equivalent coverage plan under the ACA, the ACA is violated as well.

D. Fail First and Step Therapy

Insurers often impose practitioner limitations regarding who can prescribe or provide counseling, as well as “‘fail first’ (or ‘step therapy’) criteria that require documentation that other, possibly less costly therapies have been attempted [first] but were ineffective.”²²⁰ All the while, the patient with the SUD waits for effective treatment.²²¹

In 2013, *New York State Psychiatric Ass’n, Inc. v. UnitedHealth Group*—a class action lawsuit, which was ultimately dismissed, was pending before the Southern District of New York for violations of the ACA, Equity Act, and ERISA—one of the plaintiffs suffered from severe mental illnesses and had an SUD.²²² Yet the defendant insurer dissuaded him from seeking residential treatment, stating “that his health plan [did] not cover long-term care and that [he] would need to first attempt and fail outpatient treatment as a prerequisite to precertification for higher, inpatient levels of care.”²²³

Limitations such as fail-first and step therapy protocols are explicitly listed as NQTLs in the Equity Act Final Regulations.²²⁴ However, no language in the defendant’s policy for medical/surgical services required fail first or step therapy protocols as prerequisites to inpatient services,²²⁵ making the prerequisite for MH/SUD benefits a violation of the Equity Act Final Regulations. Had the Southern District of New York reached the merits, it should have ruled in the plaintiffs’ favor, and other injured parties should make similar arguments if an insurer imposes such limitations on MH/SUD benefits but does not do so for comparable medical/surgical benefits.

220. See Rinaldo & Rinaldo, *The Avisa Group*, *supra* note 186, at 10–11.

221. See *id.* at 11.

222. Class Action Complaint at 11, 92–93, 95, *N.Y. State Psychiatric Ass’n, Inc. v. UnitedHealth Grp.*, 980 F. Supp. 2d 527 (S.D.N.Y. 2013) (No. 13 Civ. 1599 CM).

223. *Id.* at 11.

224. 29 C.F.R. § 2590.712(c)(4)(ii)(F).

225. Class Action Complaint, *supra* note 222, at 28.

E. Reimbursement Rate Cuts

According to ASAM's findings, insurers impose reimbursement limitations on SUD treatment, especially on psychological treatment, even though such services are required for MAT.²²⁶ In 2011, an insurer used this technique when it announced that it planned to terminate all of its contracts with MH care providers.²²⁷ In order to remain in the network, providers had to apply to join the network of the insurer's subsidiary.²²⁸ However, the subsidiary cut compensation rates for the most common MH services by 33% to 54%.²²⁹ There was no evidence that the rate cuts were applied to medical and surgical care providers who remained in the insurer's network.²³⁰ As a result of such policies, in the first seven months after the rate cuts went into effect, 69% of psychologists reported that the policy had disrupted treatment delivery, including 64% who said some patients had dropped out of treatment, and 61% who reported that patients had to pay additional out-of-pocket expenses to continue receiving care.²³¹

Such limitations violate the Equity Act Regulations because they are NQTLs. According to the Final Regulations, "[s]tandards for provider admission to participate in a network, including reimbursement rates" is specifically listed as an NQTL, and therefore, the Comparable Test must be applied.²³² Although many argued that it was unclear under the Interim Regulations whether discrepancies in reimbursement rates were NQTLs, the Final Regulations definitively confirmed that they are.²³³ The Final Regulations state that "[p]lans and issuers may consider a wide array of factors in determining provider reimbursement rates for both medical/surgical services and [MH/SUD] services, such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reim-

226. See Rinaldo & Rinaldo, *The Avisa Group*, *supra* note 187, at 10–11.

227. See Letter from Katherine Nordal, Exec. Dir. for Prof'l Practice, Am. Psychological Ass'n Practice Org. & Connie Galiotti, Exec. Dir., Fla. Psychological Ass'n, to Hilda Solis, Sec'y, U.S. Dep't of Labor, Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. & Timothy Geithner, Sec'y, U.S. Dep't of the Treasury 2 (Oct. 5, 2011), *available at* <http://www.apapracticecentral.org/reimbursement/rates-letter.pdf>.

228. *Id.*

229. *Id.*

230. *Id.*

231. Letter from Katherine Nordal, Exec. Dir. for Prof'l Practice, Am. Psychological Ass'n Practice Org., to U.S. Dep't of Labor, Sec'y, U.S. Dep't of Health & Human Servs., U.S. Dep't of the Treasury (Jan. 8, 2014), *available at* <http://www.apapracticecentral.org/update/2014/01-16/mental-health-parity.pdf>.

232. 29 C.F.R. § 2590.712(c)(4)(i), (ii)(D) (2013).

233. See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68245 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).

bursement rates; and training, experience and licensure of providers.”²³⁴ However, the NQTL provisions in the Final Regulations require that these and other factors must “be applied comparably to and no more stringently than those applied with respect to medical/surgical services.”²³⁵ Here, the decreased “reimbursement rates set a standard for network participation that [was] extremely low,” and yet there was no evidence that the same low reimbursement rates were applied to medical and surgical network reimbursements.²³⁶

F. Limitations on Testing for Substance Use

Testing for substance use is a major area in which insurers have found ways to discriminate against those in need of SUD treatment. Tests for substance use are used in all stages of SUD treatment, including diagnosis, active treatment, and recovery.²³⁷ The two types of SUD tests that are typically employed are preliminary and definitive tests.²³⁸ Whereas preliminary tests

234. *Id.* at 68246.

235. *Id.*

236. Letter from Katherine Nordal & Connie Galietti to Hilda Solis, Kathleen Sebelius & Timothy Geithner, *supra* note 227, at 3.

237. *Public Policy Statement on Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in Other Clinical Settings*, AM. SOC’Y ADDICTION MED. 1–2 (Oct. 2010), <http://www.asam.org/docs/public-policy-statements/1drug-testing---clinical-10-10.pdf?sfvrsn=0>.

238. CATHERINE A. HAMMETT-STABLER & LYNN R. WEBSTER, A CLINICAL GUIDE TO URINE DRUG TESTING: AUGMENTING PAIN MANAGEMENT & ENHANCING PATIENT CARE 7 (2008), available at <http://paindr.com/wp-content/uploads/2012/06/A-Clinical-Guide-to-URINE-DRUG-TESTING.pdf>; *Policy Statement on Testing for Substance Use*, CENTER FOR LAWFUL ACCESS & ABUSE DETERRENCE (Mar. 5, 2014), <http://claad.org/wp-content/uploads/2014/03/CLAAD-Policy-Statement-on-Substance-Use-Testing-140305-4.pdf>; SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TECHNICAL ASSISTANCE PUBLICATION SERIES (TAP) 32: CLINICAL DRUG TESTING IN PRIMARY CARE 9 (2012), available at <http://store.samhsa.gov/shin/content//SMA12-4668/SMA12-4668.pdf> [hereinafter TAP 32]. Preliminary tests are used to indicate the presence or absence of a class of substance or its metabolite. TAP 32, *supra*, at 9. In other words, they state whether the sample is positive or negative for the tested class of substance. Definitive tests measure the quantity of the substance or its metabolite present in the specimen. *Id.* Preliminary tests are sometimes referred to as “qualitative tests,” and definitive tests are sometimes referred to as “quantitative tests.” *Id.* The terms “qualitative” and “quantitative” are not intuitive and are easily confused. Therefore, they are not practical in daily use. Preliminary tests are also sometimes referred to as screening tests, HAMMETT-STABLER & WEBSTER, *supra*, at 7; TAP 32, *supra*, at 9, however, such terminology is imprecise and confusing because routine clinical screening for SUDs is a preventative service to deter substance use and a diagnostic tool to indicate whether the patient is likely using substances. Definitive tests are often used for clinical screening purposes, and preliminary tests are sometimes used during the active treatment and recovery phases of treatment. Definitive tests are sometimes called “confirmatory tests,” HAMMETT-STABLER & WEBSTER, *supra*, at 7–8; TAP 32, *supra*, at 10, but such terminology is imprecise

determine whether a sample is positive or negative for a tested class of substances, definitive tests can measure the quantity of a substance or its metabolite that is present in a specimen and can more reliably detect the presence of a substance in low concentrations.²³⁹ A definitive test can also identify specific substances within a substance class.²⁴⁰ This distinction is important, particularly for physicians who must monitor their patients for compliance with the prescribed SUD treatment regimen. Preliminary tests are more prone to false positives, false negatives, inaccuracies due to the lack of ability to determine how much of a substance is present, and more subjective interpretation of results.²⁴¹ In contrast, such issues are highly unlikely in a definitive test as long as the test is performed correctly.²⁴²

Yet many insurers will only cover diagnostic and therapeutic testing for SUD treatment when it is conducted using certain methods, under specific circumstances, with limited frequency, and for a predefined duration, possibly interfering with a physician's judgment.²⁴³ For instance, most state Medicaid plans and private insurance policies only find it medically necessary to provide limited coverage, and only for preliminary tests in certain circumstances—such as when the patient is in an unexplained coma, has severe or unexplained cardiovascular instability, or has seizures with an undetermined history.²⁴⁴ Insurers and Medicaid plans typically find it medically necessary

if interpreted to mean that they necessarily confirm or refute the results of a preliminary test. Definitive tests are often conducted exclusive of preliminary tests in all stages of care: diagnosis, active treatment, and recovery support. Preliminary tests may also be confirmatory in some cases.

239. *Policy Statement on Testing for Substance Use*, *supra* note 236; TAP 32, *supra* note 237, at 9.

240. TAP 32, *supra* note 238, at 9–10.

241. Barry Meier, *Increase in Urine Testing Raises Ethical Questions*, N.Y. TIMES (Aug. 1, 2013), http://www.nytimes.com/2013/08/02/business/increase-in-urine-testing-raises-ethical-questions.html?pagewanted=all&_r=0; TAP 32, *supra* note 237, at 27.

242. *See* TAP 32, *supra* note 237, at 9–10, 24–25.

243. BUREAU OF JUSTICE ASSISTANCE DRUG COURT TECHNICAL ASSISTANCE/CLEARINGHOUSE PROJECT, AM. UNIV. SCH. OF PUB. AFFAIRS, *MEDICAID COVERAGE FOR SUBSTANCE ABUSE AND RELATED SERVICES FOR DRUG COURT CLIENTS 2* (2012), *available at* <http://jpo.wrlc.org/bitstream/handle/11204/1132/4143.pdf?sequence=1>; *Public Policy Statement on Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in Other Clinical Settings*, *supra* note 236, at 3. *See, e.g.*, HEALTH PLAN, *URINE DRUG TESTING: COVERAGE AND REIMBURSEMENT GUIDELINES 1–4* (2012), *available at* <http://healthplan.org/pdf/UrineDrugTesting.pdf>; NEIGHBORHOOD HEALTH PLAN, *PROVIDER PAYMENT GUIDELINES: URINE DRUG TESTING 1* (2013), *available at* http://nhp.org/PDFs/Providers/UrineDrugTestingGuidelines_12-1-2012.pdf.

244. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., *COMMENTS: QUALITATIVE DRUG TESTING 7* (2013), *available at* http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/32450_1/32450_path035060112.pdf; HORIZON BLUE CROSS BLUE SHIELD OF N.J., *UNIFORM MEDICAL POLICY MANUAL: DRUG SCREENING/TESTING IN THE CONTEXT OF SUBSTANCE ABUSE TREATMENT* (2014), *available at* <https://services5.horizon-bcbnsj.com/>

to cover definitive tests only in special circumstances, such as to resolve inconsistent preliminary tests or to confirm positive test results, if at all.²⁴⁵ Given their inaccuracy and unreliability, preliminary tests should rarely, if ever, be used in therapeutic settings, where errors can result in drug interactions, overdoses, and deaths.²⁴⁶

Such practices of denying or limiting coverage for substance-use testing constitute NQTLs in violation of the Equity Act Final Regulations. “Medical management standards limiting or excluding benefits based on medical necessity” is one of the specific examples of an NQTL.²⁴⁷ When an insurer applies such a limitation more stringently to SUD testing for MH/SUD care than to comparable laboratory testing for medical/surgical conditions, like tests used to determine cholesterol levels or diabetes, the insurer’s policies violate the Equity Act. Insurers should avoid placing such stringent limitations on SUD testing.

G. Quantitative Limits

Insurers have also imposed quantitative limits on MH/SUD treatment, such as lifetime, annual, and age limits.²⁴⁸ Medicaid and insurance plans place lifetime limits on the prescription of methadone and buprenorphine,²⁴⁹ unlike other medications, despite evidence that shows that discontinuing treatment typically results in relapse and elevates risk of mortality.²⁵⁰ For instance, at least eleven state Medicaid plans include a definitive limit, ranging from twelve to thirty-six months, on how long a patient can receive buprenorphine benefits during his or her lifetime.²⁵¹ Furthermore, most states that do not include strict limits on buprenorphine do impose additional re-

eprise/main/horizon/content/homepage/MedPol/MedPol_2014.5.30_13.15.11; MAGELLAN BEHAVIORAL HEALTH, INC., MEDICAL NECESSITY CRITERIA GUIDELINES 73 (2014), available at https://www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/MNC.pdf.

245. See, e.g., HORIZON BLUE CROSS BLUE SHIELD OF N.J., *supra* note 243; HEALTH PLAN, *supra* note 242, at 3.

246. *Policy Statement on Testing for Substance Use*, *supra* note 238.

247. 29 C.F.R. § 2590.712(c)(4)(ii)(A) (2013).

248. See Rinaldo & Rinaldo, *The Avisa Group*, *supra* note 187, at 10, 38–39.

249. Buprenorphine is an opioid medication that the FDA has approved as safe and effective for the treatment of opioid detoxification and maintenance treatment. Ellen M. Weber, *Failure of Physicians to Prescribe Pharmacotherapies for Addiction: Regulatory Restrictions and Physician Resistance*, 13 J. HEALTH CARE L. & POL’Y 49, 49 n.2 (2010); American Society of Addiction Med., *Opioid Addiction Disease: Stabilizing Medication Access*, <http://www.asam.org/docs/default-source/advocacy/asam---opioid-addiction-disease-meds-access-2014.pdf?sfvrsn=0>, (last visited Nov. 4, 2014).

250. Rinaldo & Rinaldo, *The Avisa Group*, *supra* note 187, at 10, 3.

251. *Id.* at 34. The eleven states are Arkansas, Delaware, Illinois, Maine, Michigan, Mississippi, Montana, Utah, Virginia, Washington, and Wyoming. *Id.*

new application requirements after a similar amount of time has passed.²⁵² Many states also include limitations on refills and on the dosage that patients can receive after six months on the medication, regardless of what a physician determines is the appropriate amount.²⁵³

Such limitations are quantitative treatment limitations in violation of the Equity Act Regulations because they are expressed numerically.²⁵⁴ Unequal limitations placed on “frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope . . . of treatment” are prohibited under the Equity Act if such limitations are “more restrictive than the predominant [limitations] applied to substantially all medical/surgical benefits in the same classification,” such as maintenance medications for chronic conditions.²⁵⁵ As such, parties should bring claims under the Equity Act or state parity laws.

In *Z.D. ex rel. J.D. v. Grp. Health Coop.*, the plaintiffs filed suit on behalf of their twelve-year-old daughter who had developmental learning disabilities.²⁵⁶ When the defendant denied coverage of speech therapy treatment, claiming it only covered such therapy for children aged six years old or younger, the plaintiff sued pursuant to ERISA and Washington State’s Mental Health Parity Act, which allows voluntary participation.²⁵⁷ The defendant argued that it corrected the problem by applying the age limit to all of its therapy services because it applied the age seven cutoff to speech therapy, physical therapy, and occupational therapy, and such therapies treat medical and MH conditions alike.²⁵⁸ However, the court found that, “[i]n actuality, [the defendant did] not apply an age-based treatment limitation across the board to all therapies related to medical and surgical services.”²⁵⁹ Instead, it applied aged-based limitations solely to a narrow subcategory of medical/surgical services—non-rehabilitative therapy services.²⁶⁰ This case is important because, although the insurer “corrected” the inequity by placing the same restriction on some medical/surgical benefits that it had applied to MH/SUD benefits, supposedly bringing the plan into compliance, the court still held that the limitation violated the law.²⁶¹ The court noted that the pari-

252. *See Id.* at 61–65.

253. *Id.* at 39.

254. *See* 29 C.F.R. § 2590.712(a) (2013).

255. 29 C.F.R. § 2590.712(a), (c)(2)(i).

256. *Z.D. ex rel. J.D. v. Grp. Health Coop.*, No. C11-1119RSL, 2012 WL 1997705, at *1 (W.D. Wash. June 1, 2012).

257. *Id.* at *1–2.

258. *Id.* at *10.

259. *Id.*

260. *Id.* (“Non-rehabilitative therap[y]” was defined as “therapy for degenerative or static conditions when the expected outcome is primarily to maintain the Member’s level of functioning,” as opposed to “restore function following illness, injury or surgery.””).

261. *Id.* at *12.

ty act was intended to “bolster” coverage and not “weaken or supplant . . . baseline coverage.”²⁶² The court therefore found that the plan violated the spirit of the law even if it did not violate the letter of the law.²⁶³

H. How the ACA Factors in

In light of the implementation of the ACA, protection under the Equity Act will be even more far-reaching. The ACA has expanded parity to non-grandfathered small group plans, individual plans, Exchange plans, and Medicaid ABP plans,²⁶⁴ which means Equity Act violation claims are no longer limited to large group plans. Therefore, a significantly greater number of harmed individuals can and should seek enforcement of parity laws pursuant to the Equity Act, the ACA, and state parity laws.

III. DISCRIMINATORY POLICIES MUST BE CHALLENGED AND CHANGED

The Equity Act, Equity Act Regulations, ACA, and state parity laws theoretically allow for better access to SUD treatment. However, until such laws and regulations are properly enforced, patients will continue to struggle to obtain care while the prescription drug abuse epidemic continues to devastate families and communities. This section discusses strategies for closing loopholes and for properly enforcing parity laws in light of federal and state laws and regulations. It discusses which agencies have enforcement authority; methods of federal enforcement, such as internal appeals, lawsuits, and excise taxes; methods of enforcement under Medicaid plans; joint state and federal enforcement; state regulations and avoiding preemption; enactment of stricter state parity laws; and equal cost cutting measures.

A. Enforcement of the ACA and Equity Act

The PHSA sets forth the authority to enforce and impose penalties for noncompliance with both the Equity Act and the ACA.²⁶⁵ Pursuant to section 2723(a) of the PHSA, “states have primary enforcement authority over

262. *Z.D. ex rel. J.D.*, 2012 WL 1997705, at *12.

263. *See id.* (finding that the defendant’s application of the statute ignored its “history and structure” and created “limitations that would defeat the very purpose of the statute”).

264. 42 U.S.C. §§ 1396u-7(b)(5)–(6), 18022(b)(1)(E) (2012); 45 C.F.R. § 146.136 (2013); 45 C.F.R. § 156.115(a)(3) (2013); Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,866 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155 & 156).

265. 42 U.S.C. § 300gg-22(a) (2012); 42 U.S.C. § 18041(a)(1) (2012); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,252 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).

health insurance issuers.”²⁶⁶ A health insurance issuer is defined as “an insurance company, insurance service, or insurance organization . . . licensed to engage in the business of insurance in a State and which is subject to State law.”²⁶⁷ State insurance departments have primary authority over issuers in individual and group markets, and CMS, as a branch of HHS, has secondary enforcement authority.²⁶⁸ This means that CMS “has enforcement authority . . . if the State notifies CMS that it has not enacted legislation to enforce or is otherwise not enforcing [the ACA or Equity Act], or if CMS determines that the State is not substantially enforcing [the ACA or Equity Act].”²⁶⁹

“DOL and the IRS generally have enforcement authority over private sector employment-based [health] plans that are subject to ERISA,”²⁷⁰ whereas “HHS has direct enforcement authority [over] . . . non-Federal governmental plans,” i.e. plans sponsored by state and local government employers.²⁷¹ The three agencies “generally collaborate with one another, as appropriate, on any investigations and broad-based compliance assistance efforts” when complaints of Equity Act and ACA violations are submitted.²⁷²

The IRS, DOL, and HHS must provide a detailed framework for determining and enforcing parity compliance as well as provide instructions on how to properly bring a complaint as discussed in this section.

266. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68,252; 42 U.S.C. § 300gg-22(a); 42 U.S.C. § 18041(a)–(c) (quoting the Fed. Reg.).

267. 42 U.S.C. § 300gg-91(b)(2) (2012).

268. 42 U.S.C. § 300gg-22(a)(1)–(2); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68,252; Weber, *supra* note 214.

269. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. at 68,252; 42 U.S.C. § 18041(b)–(c) (quoting the Fed. Reg.).

270. U.S. DEP’T OF LABOR, REPORT TO CONGRESS: COMPLIANCE OF GROUP HEALTH PLANS (AND HEALTH INSURANCE COVERAGE OFFERED IN CONNECTION WITH SUCH PLANS) WITH THE REQUIREMENTS OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, at 22 (2012), *available at* <http://www.dol.gov/ebsa/publications/mhpaereporttocongress2012.html>. ERISA employee benefit plans include all private sector employee benefit plans except for church plans; plans in which the sole purpose is to comply with workers’ compensation, unemployment, or disability insurance laws; plans maintained outside of the U.S. primarily for the benefit of non-resident aliens; or excess benefit plans. 29 U.S.C. § 1003(a)–(b) (2012). Additionally, ERISA does not cover governmental plans. *Id.*

271. U.S. DEP’T OF LABOR, *supra* note 252; 42 U.S.C. § 300gg-22(b)(1)(B). (Quote from DOL)

272. U.S. DEP’T OF LABOR, *supra* note 252; JENNIFER STAMAN, CONG. RESEARCH SERV., R41624, ENFORCEMENT OF PRIVATE HEALTH INSURANCE MARKET REFORMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 5 (2011), *available at* <http://www.ppsv.com/assets/attachments/crsreport.pdf>.

1. *Enforcement Through Internal Appeals Process*

The ACA sets forth specific rules governing adverse benefit determinations and their appeals.²⁷³ For instance, “[t]he plan or issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.”²⁷⁴ The plan or issuer may not reduce or terminate “an ongoing course of treatment without providing advance notice and an opportunity for advance review.”²⁷⁵ As such, if coverage has been denied, the insured should request a copy of the denial letter explaining the reason for any denial of reimbursement or payment and disclosure of the criteria for medical necessity determinations regarding MH/SUD benefits.²⁷⁶ He should then file an internal appeal in which his insurance company conducts its own “full and fair review of its decision.”²⁷⁷ It is important to note that the ACA and its interim final regulations “require a plan and issuer to provide continued coverage pending the outcome of an internal appeal.”²⁷⁸

If the internal appeal is unsuccessful, the insured may then request an external review in which an independent third party reviews the decision.²⁷⁹ If the external reviewer overturns the insurer’s denial, the insurer must give the insured the payments or services requested in the insured’s claim.²⁸⁰

273. Class Action Complaint at 111, *N.Y. State Psychiatric Ass’n, Inc. v. UnitedHealth Grp.*, 980 F. Supp. 2d 527 (S.D.N.Y. 2013) (No. 13 CV 1599 CM).

274. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,330, 43,333 (July 23, 2010) (to be codified at 26 C.F.R. pts. 54 & 602; 29 C.F.R. pt. 2590; 45 C.F.R. pt. 147).

275. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,334.

276. Under the Equity Act Final Rules, all covered plan participants are entitled to an explanation of the denial as well as an explanation of the plan’s medical necessity determinations. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,247 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).

277. See *How to Appeal a Health Plan Decision*, HEALTHCARE.GOV, <https://www.healthcare.gov/how-do-i-appeal-a-health-insurance-companys-decision/> (last visited Mar. 31, 2014). All plans must implement an effective internal appeals process of coverage determinations and claims and comply with any applicable state external review process. 42 U.S.C. § 300gg-19(a)(1), (b)(1) (2012).

278. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 43,334; 42 U.S.C. § 300gg-19(a)(1)(C). (Quote from FR)

279. *How to Appeal a Health Plan Decision*, *supra* note 260.

280. *Appealing Health Plan Decisions*, U.S. DEP’T HEALTH & HUM. SERVICES, <http://www.hhs.gov/healthcare/rights/appeal/appealing-health-plan-decisions.html> (last visited Mar. 31, 2014).

2. *Enforcement Through Federal Lawsuits*

If an appeal is unsuccessful, the next step may be to bring a suit. At the federal level, individuals with employee benefit plans should bring suits under ERISA to challenge a denial of benefits that violates the ACA or Equity Act.²⁸¹ “Almost all health benefits plans offered through private employers are governed by ERISA,” and ERISA preempts state law.²⁸² Under § 502(a) of ERISA, plan participants and beneficiaries can challenge Equity Act violations by bringing a case “to recover benefits due to [them] under the terms of [their] plan[s], to enforce [their] rights under the terms of the plan[s], or to clarify [their] rights to future benefits under the terms of the plan[s].”²⁸³

In bringing a claim to challenge a denial of benefits, an individual may “challenge the underlying standard that was the basis for the denial of coverage or reimbursement as being non-compliant with the [Equity] Act.”²⁸⁴ The plaintiff should make his case using a two-part test: first, allege that the “erroneous application of the plan’s medical necessity criteria or other standard resulted in the denial of care or reimbursement”; and second, allege “that the application of non-comparable medical necessity criteria or other medical management standards violated the [Equity] Act.”²⁸⁵

Alternatively, by bringing a claim to enforce employee benefit rights, the individual can “challenge a wide range of non-compliant plan design features . . . that can be addressed prospectively, without awaiting . . . denial” of a health service.²⁸⁶ The individual can challenge a plan for “any act or practice” that violates ERISA provisions, including the Equity Act.²⁸⁷ Such

281. 29 U.S.C. § 1132(a) (2012); see *Daniel F. v. Blue Shield of Cal.*, No. C 09–2037 PJH, 2011 WL 830623, at *6 (N.D. Cal. Mar. 3, 2011) (an example of a plaintiff bringing a claim under ERISA § 502 for federal parity violations). The Equity Act and the ACA do not include a private right of action for individuals to bring suit. Therefore, harmed parties with employer-sponsored plans would have to challenge Equity Act and ACA violations by bringing suit under § 502(a) of ERISA since both the Equity Act and the ACA are amendments to ERISA. See 29 U.S.C. § 1132(a); Weber, *supra* note 248, at 224–25.

282. *Chapter VIII.: Your Rights to Appeal and Litigate Benefit Denials Under ERISA*, CAL. PATIENT’S GUIDE, <http://www.calpatientguide.org/viii.html> (last visited Mar. 31, 2014) (emphasis omitted).

283. 29 U.S.C. § 1132(a)(1)(B); Weber, *supra* note 249, at 225–26.

284. Weber, *supra* note 249, at 225.

285. *Id.* at 226.

286. *Id.* at 225–26.

287. 29 U.S.C. § 1132(a)(3). Although an individual can bring a case under ERISA for an Equity Act violation, *C.M. v. Fletcher Allen Health Care, Inc.* is the only case thus far in which a court has considered the Equity Act Regulations. No. 5:12-cv-00108, 2013 WL 4453754 (D. Vt. Apr. 30, 2013). However, *Fletcher* is now irrelevant because the holding pertained to a part of the Interim Regulations that was excluded from the Final Regulations. Under the Comparable Test in the Interim Regulations, limitations on MH/SUD must be no

violations may include more restrictive financial requirements, quantitative treatment limitations, and NQTLs, among other things.²⁸⁸ “ERISA limits the remedies for violations of [the Equity Act] to equitable relief: the provision of the benefit allowed under the plan or reimbursement for cost of the care.”²⁸⁹

Summary judgment is an important mechanism for Equity Act cases brought under ERISA. The court in *Daniel F. v. Blue Shield of Cal.* summarized the process as follows:

Ordinarily, summary judgment is appropriate if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. However, “where the abuse of discretion standard applies in an ERISA benefits denial case, a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exists, do not apply.”²⁹⁰

To date, no federal parity case appears to have made it past summary judgment, likely because when cases are dismissed on summary judgment, the matters end, and when the cases survive summary judgment, the parties typically settle.²⁹¹

3. *Excise Tax*

Pursuant to the IRC, those who violate the Equity Act or the ACA may also face a federal excise tax.²⁹² Employers are generally responsible for paying the tax for single-employer plans, and the tax is imposed on the plan for multiemployer plans.²⁹³ An employer must pay a tax of \$100 per day for each individual who was harmed by the employer’s Equity Act or ACA vio-

more stringent than those placed on comparable medical/surgical benefits, “*except to the extent that recognized clinically appropriate standards of care may permit a difference.*” *Id.* at *3 (quoting 29 C.F.R. § 2590.712(c)(4)(i) (2013)). The court held that the defendant had an affirmative duty to prove that a recognized clinically appropriate standard of care was applicable. *Id.* at *7. However, the Final Regulations omitted the “clinically appropriate standards of care” language due to its potential for abuse.

288. Weber, *supra* note 248, at 229.

289. Weber, *supra* note 248, at 226; *see* 29 U.S.C. § 1132(a)(1)(B), (3).

290. *Daniel F. v. Blue Shield of Cal.*, No. C 09–2037 PJH, 2011 WL 830623, at *4 (N.D. Cal. Mar. 3, 2011) (citation omitted) (quoting *Nolan v. Heald College*, 551 F.3d 1148, 1154 (9th Cir. 2009)).

291. The authors of this article did an extensive and exhaustive search of federal case law and found no MHPA or Equity Act cases that have passed the summary judgment stage. *See also* ERWIN CHEMERINSKY, *ENHANCING GOVERNMENT: FEDERALISM FOR THE 21ST CENTURY* 183 (2008).

292. 26 U.S.C. §§ 4980D, 4980I (2012).

293. 26 U.S.C. § 4980I(c)(1)–(2).

lation, and the tax liability continues for the duration of the noncompliance period.²⁹⁴ Where violations are considered to be more than de minimis, the amount will not be less than \$15,000.²⁹⁵ However, the amount of tax is subject to limitations, and there are several instances in which it does not apply, such as if the employer did not know and would not have known after exercising reasonable diligence that it failed to comply with the Equity Act or the ACA; “if the violation is due to reasonable cause and not willful negligence”; and if “the employer corrected the violation within thirty days of the date it knew or should have known of its failure to comply.”²⁹⁶

A harmed individual cannot file a complaint to seek imposition of the excise tax. Instead, employers are required to self-report such violations.²⁹⁷ Moreover, whereas employers were initially required to report annually, the Equity Act Final Regulations changed this requirement, stating “that the parity analysis would not need to be performed annually absent changes in plan design or indications that assumptions or data were inaccurate.”²⁹⁸

Failure to file the excise tax return and pay the excise tax on or before the required due date will result in further penalties and related interest unless the failure to timely file or pay is “due to reasonable cause and not to willful neglect.”²⁹⁹ However, if a noncompliant employer fails to self-report, an aggrieved individual can report the employer’s noncompliance by filing a complaint under the IRS whistleblower procedures.³⁰⁰ If the employee’s complaint leads to the successful collection of unpaid taxes from a noncompliant employer, the whistleblower may be entitled to 15 to 30 percent of the proceeds.³⁰¹

294. 26 U.S.C. §§ 4980D(a)–(b)(1), (e)(1), 4980I(c)(1)–(2); Weber, *supra* note 249, at 230.

295. 26 U.S.C. § 4980D(b)(3)(B).

296. 26 U.S.C. § 4980D(c); Weber, *supra* note 248, at 230.

297. Employer Comparable Contributions to Health Savings Accounts Under Section 4980G, and Requirement of Return for Filing of the Excise Tax Under Section 4980B, 4980D, 4980E or 4980G, 74 Fed. Reg. 45,994, 46,000 (Sept. 8, 2009) (to be codified at 26 C.F.R. pt. 54).

298. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,243 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).

299. 26 U.S.C. § 4980I(e).

300. See 26 U.S.C. § 7623 (2011). For a description of the whistleblower process, see *How Do You File a Whistleblower Award Claim Under Section 7623(a) or (b)*, IRS, [http://www.irs.gov/uac/How-Do-You-File-a-Whistleblower-Award-Claim-Under-Section-7623-\(a\)-or-\(b\)](http://www.irs.gov/uac/How-Do-You-File-a-Whistleblower-Award-Claim-Under-Section-7623-(a)-or-(b)) (last updated Apr. 30, 2014).

301. See 26 U.S.C. § 7623(b)(1). The claimant can fill out IRS Form 211 to initiate an investigation. See *Form 211: Application for Award for Original Information*, IRS (Mar. 2014), <http://www.irs.gov/pub/irs-pdf/f211.pdf>.

4. *Enforcing the Equity Act and the ACA in Medicaid Plans*

Medicaid plays a large role in funding mental health and substance use care, paying nearly 60% of mental health care costs across the country,³⁰² compared to less than 30% of total health care costs.³⁰³ And yet, as established in the previous part of this Article, Medicaid plans are continuously out of compliance with the Equity Act.³⁰⁴

Also troubling, the Final Regulations state that they do not apply to MCOs or Medicaid ABPs and that such plans are governed by guidance issued by CMS instead.³⁰⁵ This statement created a misconception that the Equity Act regulations, in general, do not apply to Medicaid plans. However, that is not the case. The CMS guidance “adopted the basic framework of the [Equity Act].”³⁰⁶ Furthermore, it stated that ABPs must comply with the Equity Act provisions regarding financial requirements and both quantitative and non-quantitative treatment limitations.³⁰⁷ Although it found that MCOs are governed by their contracts with states rather than the Final Rules, such plans must comply with their contracts and with a list of specific parity standards, which include the following:

- Medical management techniques used by the MCO, such as pre-authorization requirements, which are applied to [MH/SUD] benefits must be comparable to and applied no more stringently than the medical management techniques that are applied to medical/surgical benefits.
- Any benefits offered by an MCO beyond those specified in the Medicaid state plan also must be compliant with [the Equity Act].

302. Paige Winfield Cunningham, *Politico: ACA MH Parity Guarantees Limited . . . When Therapists Don't Accept Insurance*, N.Y. ASS'N PSYCHIATRIC REHABILITATION SERVICES (Mar. 5, 2013), <http://www.nyaprs.org/e-news-bulletins/2013/005284.cfm>.

303. See Klees, Wolfé, & Curtis, *supra* note 37, at 4, 25.

304. See *supra* Part II.

305. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,252 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).

306. *Id.*

307. See CINDY MANN, CTRS. FOR MEDICARE & MEDICAID SERVS., SHO # 13-001, STATE HEALTH OFFICIAL LETTER RE: APPLICATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT TO MEDICAID MCOs, CHIP, AND ALTERNATIVE BENEFIT (BENCHMARK) PLANS 2 (Jan. 16, 2013), *available at* <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

- In accordance with [the Equity Act] and federal Medicaid managed care regulations at 42 CFR 438 Subpart F,³⁰⁸ the criteria for medical necessity determinations made under the plan for [MH/SUD] benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request. The reasons for any denial of reimbursement or payment with respect to [MH/SUD] benefits must be provided to plan participants and beneficiaries upon request within a reasonable time.
- When out-of-network coverage is available for medical/surgical benefits, it also must be available for [MH/SUD] benefits. States are responsible for assessing their contracts with all MCOs that offer medical and surgical benefits and [MH/SUD] benefits, to ensure that plans comply with the provisions of [the Equity Act] as set forth [in the bullet points] above.³⁰⁹

Furthermore, state Medicaid plans may choose to enforce all of the Equity Act regulations, and some state contracts incorporate the Equity Act and its regulations. For instance, New Jersey's MCO contract states that Medicaid services shall be provided in accordance with "all applicable federal and State statutes, rules, and regulations including the [Equity Act and the ACA]," and Texas's MCO contract states that "services may be subject to . . . non-quantitative treatment limitations, provided such limitations comply with the requirements of the [Equity Act]."³¹⁰

If harmed individuals participate in Medicaid plans that do not comply with these requirements, they should file appeals of coverage denials and request state hearings,³¹¹ or, for systematic denials, such as those commonly imposed on SUD benefits, plaintiffs can band together and file a class action suit.³¹² For instance, in *Peacock ex rel. NB v. District of Columbia*,³¹³ "[f]ive

308. These regulations govern the grievance system for persons with Medicaid whose claims for assistance are denied or not acted upon promptly. 42 C.F.R. § 438.400 (2013).

309. CINDY MANN, CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 306, at 3.

310. *Contract Between State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and _____, Contractor*, STATE OF NEW JERSEY art. 4.1 (Jan. 2014), <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>; *Uniform Managed Care Terms & Conditions*, TEX. HEALTH & HUM. SERVICES COMMISSION 336, <http://www.hhsc.state.tx.us/medicaid/UniformManagedCareContract.pdf> (last visited Mar. 31, 2014).

311. *Parity Toolkit for Addiction & Mental Health Consumers, Providers & Advocates*, PARITY IMPLEMENTATION COALITION 9–11, 28 (Sept. 2010), [http://parityispersonal.org/sites/default/files/pdfs/Parity %20Toolkit.pdf](http://parityispersonal.org/sites/default/files/pdfs/Parity%20Toolkit.pdf). For a full explanation of the Medicaid Appeals Process, see MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, HENRY J. KAISER FAM. FOUND. (Mar. 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

312. See *Peacock ex rel. NB v. District of Columbia*, 682 F.3d 77 (D.C. Cir. 2012).

Medicaid recipients filed [a] class action against the District of Columbia, alleging that the District [had] systematically denie[d] Medicaid coverage of prescription medications without providing the written notice required by federal and D.C. law.”³¹⁴ The district court dismissed the case, concluding the “plaintiffs lacked standing to pursue their claims for injunctive and declaratory relief” because not all of the class members established standing.³¹⁵ On appeal, the District of Columbia Circuit ruled that at least one member of the class “sufficiently establish[ed] injury, causation, and redressability,” and therefore there was “no need to decide whether the other plaintiffs [had] standing.”³¹⁶ The court also noted that “[s]tates electing to participate in Medicaid must comply with requirements imposed by federal law.”³¹⁷ This includes compliance with provisions of the Equity Act and ACA that apply to Medicaid, and therefore, class actions may be brought to challenge Medicaid plans for noncompliance with such federal regulations.

Additionally, the private insurance requirements of Title XXVII of the PHSa apply to government plans, including Medicaid.³¹⁸ Under the PHSa, HHS may take enforcement action and impose civil penalties against health insurance issuers in a state if the Secretary determines that a state has failed to substantially enforce an Equity Act or ACA provision with respect to a government plan.³¹⁹

5. *Joint Federal and State Enforcement of the ACA*

Similar to the enforcement methods for Medicaid, states primarily enforce the ACA with respect to individual and group market insurance and can require insurers to meet federal standards.³²⁰ If, however, a state fails to substantially enforce all or parts of the ACA, or if the state notifies the federal government that it does not have the authority to enforce or is not enforcing the law, federal regulators at CMS may intervene.³²¹ As of January

313. *Id.*

314. *Id.* at 80.

315. *Id.* at 80–81.

316. *Id.* at 86–87.

317. *Id.* at 80.

318. STAMAN, *supra* note 272, at 5, 7; STATE HEALTH OFFICIAL LETTER RE: APPLICATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT TO MEDICAID MCOs, CHIP, AND ALTERNATIVE BENEFIT (BENCHMARK) PLANS 3, *supra* note 307.

319. 42 U.S.C. § 300gg-22(a)(2), (b)(2)(A) (2012); STAMAN, *supra* note 272, at 7–8.

320. *See* 45 C.F.R. § 150.101(b)(2) (2013).

321. *Id.*; *Ensuring Compliance with the Health Insurance Market Reforms*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html> (last visited Mar. 31, 2014). CMS has enforcement authority pursuant to sections 2723 and 2761 of the PHSa, and rulemaking authority pursuant to section 2792 of the PHSa, allowing it to govern group health plans that are non-federal governmental plans under the ACA. *Id.* § 150.101(a)–(b); 42 U.S.C. §§

1, 2014, five states—Alabama, Missouri, Oklahoma, Texas, and Wyoming—“have notified CMS that they do not have the authority to enforce or are not otherwise enforcing the [ACA].”³²²

Federal regulators have the authority to impose civil money penalties per violation of the ACA of \$100 a day for each individual that is affected by an insurer’s noncompliance.³²³ “At any time, a state that is willing and able may assume enforcement authority of the [ACA] standards.”³²⁴ At such time, “CMS will work with the state to ensure an effective transition.”³²⁵ “These arrangements allow CMS to leverage the expertise of the states in monitoring their marketplaces and avoid dual regulation of insurers at the state and federal levels.”³²⁶ “This approach also may minimize consumers’ confusion and duplication of efforts by the states and CMS.”³²⁷

It is unclear, though, how the new arrangements align with existing federal regulations that require CMS to make a formal determination that a state has not substantially enforced federal law before [deciding to intervene]. Further clarification will be needed to address questions about: 1) whether CMS can bring an enforcement action against an insurer without first making a formal determination that the state is not substantially enforcing; and 2) whether federal law allows insurers to be subject to penalties at both the federal and state levels for the same violation. Because questions remain about the coordination that might be required between state and federal regulators, states should consider whether new legislation or regulations—either to amend existing state law or give their insurance department more authority—are more appropriate to address enforcement gaps, continue meaningful regulatory oversight, and promote consumer protections at the state level.³²⁸

300gg-21(a)(1), 300gg-61(b), 300gg-92 (2012); Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,841 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155 & 156).

322. *Ensuring Compliance with the Health Insurance Market Reforms*, *supra* note 321.

323. 45 C.F.R. § 150.315 (2013).

324. *Ensuring Compliance with the Health Insurance Market Reforms*, *supra* note 321.

325. *Id.*

326. Katie Keith & Kevin Lucia, *New Guidance: Federal Regulators Allow “Collaborative Arrangements” for ACA Enforcement*, COMMONWEALTH FUND (Apr. 5, 2013), <http://www.commonwealthfund.org/Blog/2013/Apr/Federal-Regulators-Allow-Collaborative-Arrangements.aspx>.

327. *Id.*

328. *Id.*

B. State Regulations and Enforcement

“Overall, the federal government . . . only weakly enforced parity, while the issuance of [the Equity Act] final rule [was] delayed for years.”³²⁹ Enforcement of the Equity Act’s Interim Final Rule often defaulted to state insurance boards, commissioners of health, or analogous agencies.³³⁰ Decisions could then be appealed in state courts under the state’s parity laws. State parity claims typically are presented in the form of breach of contract claims because insurance policies are treated as contracts, and most insurance policies contain a clause stating that they will comply with state law.³³¹ However, injured parties should be careful to avoid ERISA preemption. This section discusses preemption and the need for stronger state parity laws.

1. Preemption

The Equity Act Final Regulations state that the Equity Act requirements should not “be construed to supersede any provision of State law which establishes, implements, or continues . . . any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a [federal parity] requirement.”³³² The preemption provision also applies to individual health insurance coverage but does not mention any other type of plan.³³³ “[T]his is intended to be the ‘narrowest’ preemption of State laws,” and states may enact more stringent laws, such as parity mandates.³³⁴

329. Dennis Grantham, *Questions About Essential Health Benefits, Medicaid Expansion, and Parity Enforcement?*, BEHAV. HEALTHCARE (May 22, 2013), <http://www.behavioral.net/article/questions-about-essential-health-benefits-medicaid-expansion-and-parity-enforcement>.

330. *Id.*

331. *See, e.g.*, *Daley v. Marriott Int’l, Inc.*, 415 F.3d 889, 891 (8th Cir. 2005); *B.C. v. Blue Cross of Cal.*, No. CV 11-08961 GAF (AJWx), 2012 WL 12782, at *1 (C.D. Cal. Jan. 3, 2012); *Beye v. Horizon Blue Cross Blue Shield of N.J.*, 568 F. Supp. 2d 556, 563 (D.N.J. 2008); *Arce v. Kaiser Found. Health Plan, Inc.*, 104 Cal. Rptr. 3d 545, 552 (Cal. Ct. App. 2010).

332. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,252 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146 & 147).

333. *See id.* at 68,252 n.49.

334. *Id.* at 68, 252.

However, plaintiffs should be careful to avoid preemption under ERISA when bringing a claim for a violation of their state parity act.³³⁵ ERISA “supersede[s] any and all State laws” pertaining to a covered employee benefit plan.³³⁶ ERISA employee benefit plans include those that are established or maintained by any private employer.³³⁷ In *Daley v. Marriott International, Inc.*,³³⁸ the defendants’ plan placed annual and lifetime limits on the number of in-network, outpatient mental health visits.³³⁹ When they denied the plaintiff coverage after she exceeded the limit of visits, she sued for breach of contract under the state parity laws and breach of fiduciary duty under ERISA, “alleg[ing] that the Plan failed to provide mental-health coverage in accordance with Nebraska’s mental-health parity law.”³⁴⁰ The Eighth Circuit held that “ERISA broadly preempts ‘any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.’”³⁴¹ “ERISA contains an exception to the general rule of preemption, which is referred to as the ‘savings clause.’”³⁴² “Under the savings clause, a state law that regulates insurance is ‘saved’ from ERISA preemption.”³⁴³ Yet “ERISA’s ‘deemer clause,’ in turn, ‘exempt[s] self-funded ERISA plans from state laws that ‘regulat[e] insurance’ within the meaning of the savings clause.’”³⁴⁴ “The effect of the deemer clause is that ‘self-funded ERISA plans are exempt from state regulation insofar as that regulation ‘relate[s] to’ the plans.’”³⁴⁵ A self-funded plan is one in which, rather than buying insurance coverage, an employer puts money directly into the plan, and the employee uses such funds to pay for benefits in a “pay-as-you-go” manner.³⁴⁶ The court held that because Nebraska’s mental health parity “law ‘relates to’ an ERISA employee benefit plan, ERISA’s deemer clause exempts [the defendant’s] self-funded Plan from application of [the state] mental-health parity law.”³⁴⁷

335. See, e.g., *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 738–48 (1985); *Beye*, 568 F. Supp. 2d at 566–70; *DeVito v. Aetna, Inc.*, 536 F. Supp. 2d 523, 529–31 (D.N.J. 2008).

336. 29 U.S.C. § 1144(a) (2012).

337. 29 U.S.C. § 1003(a) (2012).

338. 415 F.3d 889 (8th Cir. 2005).

339. *Id.* at 892.

340. *Id.* at 891–92.

341. *Id.* at 894. Any “law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.” *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96–97 (1983).

342. *Daley*, 415 F.3d at 894.

343. *Id.* (citing 29 U.S.C. § 1144(b)(2)(A)).

344. *Id.* (alteration in original) (quoting *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990)).

345. *Id.* at 894–95 (alteration in original) (quoting *FMC Corp.*, 498 U.S. at 61).

346. Peter Schmidt, *The Basics of ERISA as It Relates to Health Plans*, EBRI ISSUE BRIEF, Nov. 1995, at 2, 5, available at <http://www.ebri.org/pdf/briefspdf/1195ib.pdf>.

347. *Daley*, 415 F.3d at 895.

Furthermore, in *DeVito v. Aetna, Inc.*, another case in which the plaintiff brought a suit for violations of state parity laws, the court reiterated the following:

[I]f an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls “within the scope of” ERISA § 502(a)(1)(B). In other words, if an individual, at some point in time, could have brought his claim under ERISA § 502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant’s actions, then the individual’s cause of action is completely preempted by ERISA § 502(a)(1)(B).³⁴⁸

Therefore, individuals should avoid bringing state parity claims against self-funded companies and should file ERISA claims in such instances. For all other insurers, plaintiffs should continue to challenge parity violations under both federal regulations and state parity laws.³⁴⁹

2. *Enacting Stricter State Parity Laws*

The plain text of the Equity Act requires that MH and SUDs receive the same level of coverage that is provided for other medical care.³⁵⁰ This is also the minimum standard for state parity laws, known herein as “voluntary coverage.”³⁵¹ Unfortunately, the Equity Act only applies to plans that choose to voluntarily offer SUD benefits in addition to medical and surgical benefits, and the ACA only requires SUD benefits for small group plans, individual plans, Exchange plans, and Medicaid ABPs.³⁵² This means that large group plan coverage of SUD benefits is optional.

To close this loophole, states should follow the lead of Vermont’s parity law, which provides for mandatory and equivalent coverage.³⁵³ Similarly,

348. *DeVito v. Aetna, Inc.*, 536 F. Supp. 2d 523, 530 (D.N.J. 2008) (quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004)).

349. See Justin C. Wilson, Comment, *Will Full Benefits Parity Create Real Parity?—Congress’s Second Attempt at Ending Discrimination Against Mental Illness: The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008*, 3 ST. LOUIS U. J. HEALTH L. & POL’Y 343, 379 n.255 (2010).

350. 29 U.S.C. § 1185a (2012). See, e.g., *Carcieri v. Salazar*, 555 U.S. 379, 387 (2009) (“[T]o apply settled principles of statutory construction . . . we must first determine whether the statutory text is plain and unambiguous. . . . If it is, we must apply the statute according to its terms.”).

351. Some states, like Pennsylvania, have in fact explicitly adopted the federal parity rules. See 40 PA. CONS. STAT. ANN. § 908-14 (West 2014).

352. 29 U.S.C. § 1185a(b)(1).

353. See *supra* notes 145–46 and accompanying text.

in Illinois, which also has mandatory and equivalent coverage laws, the Department of Insurance issued a press release stating that it is “committed to the principle set forth in [the Equity Act] that coverage for [MH/SUD] benefits must be equivalent to coverage for other benefits,” and that “[i]n the event that ambiguity is argued to exist in the implementation of [the Equity Act] or its regulations, the Department will resolve such ambiguity in favor of the patients and families . . . whom the law is meant to protect.”³⁵⁴ Illinois’s parity laws not only comply with the Equity Act and its regulations, but they also require parity for SUDs as a mandatory and equivalent coverage requirement, making them more stringent than the voluntary coverage federal law.³⁵⁵

Looser state laws, such as those that do not provide for SUD coverage in addition to MH coverage, are invalid under the Equity Act, which only authorizes equal or more restrictive laws.³⁵⁶ In light of the ACA requirements and the Equity Act Final Rule, any state parity law that allows less than mandatory and equivalent coverage of non-grandfathered small group plans, individual plans, Exchange plans, or Medicaid ABPs would be preempted by the adoption of the Equity Act, the ACA, and the Regulations. Therefore, state parity acts that allow for less than mandatory or equivalent coverage in violation of the federal statutes and regulations should be amended so that parity applies to all plans.

C. Equal Cost Cutting

Rising health insurance costs are a major concern of public and private insurers. Nevertheless, policy makers must seek to reduce costs of care equitably for both medical/surgical benefits and MH/SUD benefits. Insurers can practice cost cutting without sacrificing care through patient activation, i.e., engaging consumers in prevention, health promotion, care-rationing, and cost saving. Patients who are more involved in their health care decisions, referred to as having “higher levels of patient activation,” consistently have significantly reduced medical costs.³⁵⁷ For instance, patients can choose less

354. Press Release, State of Ill. Dep’t of Ins., Statement from Illinois Department of Insurance on Interpretation of Federal Mental Health Parity Law (Jan. 5, 2011), available at <http://www3.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=9145>.

355. ILL. ALCOHOLISM & DRUG DEPENDENCE ASS’N. & CMTY. BEHAVIORAL HEALTHCARE ASS’N OF ILL., KNOW YOUR PARITY RIGHTS 2–4 (2013), available at http://www.iadda.org/pdfdocs/parity_rights.pdf.

356. Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 406–07 (2010).

357. See Jessica Greene & Judith H. Hibbard, *Why Does Patient Activation Matter? An Examination of the Relationships Between Patient Activation and Health-Related Outcomes*, 27 J. GEN. INTERNAL MED. 520, 520 (2012).

expensive alternatives to emergency room visits, such as retail clinics, to treat non-threatening illnesses.³⁵⁸ They can ask physicians questions regarding costs of certain services and determine whether such services are necessary or whether there are less expensive options.

Prevention services can also reduce health care costs. For instance, Screening, Brief Intervention, and Referral to Treatment (SBIRT), a three-step, “comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with [SUDs], as well as those who are at risk of developing [such] disorders,” has been shown to produce cost savings in reduced health expenditures of \$3.81 for every \$1.00 spent, which is a possible savings of \$1.2 billion annually.³⁵⁹ Through such actions, rising costs may be stunted, even if marginally. Regardless of the techniques employed to reduce healthcare spending, it is important that cost cutting should apply equally to all kinds of health care—physical, surgical, MH, and SUD services.

IV. CONCLUSION

Despite attempts to expand substance use benefits under the Equity Act, the ACA, and state parity laws, both private and public insurers have consistently denied adequate access to care for patients with SUDs due to various ambiguities and loopholes. Should individuals with SUDs face discrimination through noncompliant plans, they should seek enforcement by insurance boards, or administrative, state, or federal courts. Plaintiffs may also seek enforcement through the IRS whistleblower provisions for an employer’s failure to meet certain group health plan requirements under ERISA, for Equity Act violations, or for noncompliance with the ACA. States should enact or amend current state parity laws so that they are more stringent than the Equity Act and mandate SUD benefits for all insurance plans. Likewise, insurers should amend their plans proactively to comply with the Equity Act, the Equity Act Final Rule, and the ACA. They should apply cost-cutting measures evenly and fairly to medical/surgical benefits if those measures are imposed on mental health/SUD benefits. As these measures are consistently taken, the treatment gap for the millions of individuals with SUDs may finally close, avoiding needless deaths, and achieving the goals of federal legislation.

358. Donna Fuscaldo, *5 Easy Ways to Reduce Your Health-Care Costs*, FOX BUS. (July 2, 2013), <http://www.foxbusiness.com/personal-finance/2013/07/02/5-easy-ways-to-reduce-your-health-care-costs/>.

359. *About Screening, Brief Intervention, and Referral to Treatment (SBIRT)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., <http://beta.samhsa.gov/sbirt/about> (last updated Apr. 24, 2014); Larry M. Gentilello et al., *Alcohol Interventions in a Trauma Center as a Means of Reducing the Risk of Injury Recurrence*, 230 ANNALS SURGERY 473 (1999).