Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity

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Abstract Over the past twenty-five years, thirty-seven states and the US Congress have passed mental health and substance use disorder (MH/SUD) parity laws to secure nondiscriminatory insurance coverage for MH/SUD services in the private health insurance market and through certain public insurance programs. However, in the intervening years, litigation has been brought by numerous parties alleging violations of insurance parity. We examine the critical issues underlying these legal challenges as a framework for understanding the areas in which parity enforcement is lacking, as well as ongoing areas of ambiguity in the interpretation of these laws. We identified all private litigation involving federal and state parity laws and extracted themes from a final sample of thirty-seven lawsuits. The primary substantive topics at issue include the scope of services guaranteed by parity laws, coverage of certain habilitative therapies such as applied behavioral analysis for autism spectrum disorders, credentialing standards for MH/SUD providers, determinations regarding the medical necessity of MH/SUD services, and the application of nonquantitative treatment limitations under the 2008 federal parity law. Ongoing efforts to achieve nondiscriminatory insurance coverage for MH/SUDs should attend to the major issues subject to private legal action as important areas for facilitating and monitoring insurer compliance.

Keywords Mental Health Parity and Addiction Equity Act, insurance parity, mental health and substance use disorders, public health litigation, health reform

Research reported in this publication was supported by the National Institute of Mental Health of the National Institutes of Health under Award Number 1R01MH093414, PI: Barry, and T32MH019733, PI: McGuire. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. The authors also gratefully acknowledge funding from the National Institute on Drug Abuse via the Brandeis/Harvard Center to Improve System Performance of Substance Use Disorder Treatment (NIDA Grant #P30 DA035772).

Journal of Health Politics, Policy and Law, Vol. 42, No. 6, December 2017
DOI 10.1215/03616878-4193630

Over the past twenty-five years, thirty-seven states have passed mental health and substance use disorder (MH/SUD) parity laws, and the US Congress has passed multiple federal parity laws, including the Mental Health Parity Act of 1996, the Medicare Improvement for Patients and Providers Act of 2008, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. The MHPAEA requires that health insurers choosing to cover MH/SUD services offer these benefits at levels at least as generous as benefits for other medical conditions. With the extension of the MHPAEA via the Affordable Care Act (ACA) to new populations covered under Marketplace plans, some form of parity in benefits is now required in virtually all commercial plans, Medicaid, and the Children's Health Insurance Program, with few exceptions.[1]

These federal and state parity laws represent an important policy mechanism through which MH/SUD treatment advocates have advanced the objective of securing nondiscriminatory insurance coverage for MH/SUD services in the private health insurance market and through certain public insurance programs. However, numerous parties have brought lawsuits alleging violations of federal and state parity laws. This litigation reflects areas in which consumers and advocates believe parity law requirements are not being fully complied with. An understanding of the policy issues underlying these legal challenges can provide an important framework for assessing the areas in which parity laws are allegedly not being strictly enforced, as well as areas of ongoing ambiguity in the interpretation of these laws.

Although legal scholars have examined specific legal actions around insurance parity, no comprehensive assessment of the policy issues underlying these actions has been conducted (Cheng 2008; Greene 2013; Lagreca 2013). We collected and analyzed all private litigation alleging violations of state and federal parity requirements through 2015 and identified themes in these legal actions related to parity compliance concerns that may warrant additional monitoring. After providing a brief background on the policy and regulatory context and the role of the courts in this policy area, we report our results and what they reveal

1. Groups still exempt from MHPAEA requirements include those insured through traditional Medicare fee-for-service; Medicare Advantage "stand alone" Plans or Part A, B, and D benefits in employer Medicare Advantage Plans; fee-for-service Medicaid options with the exception of Alternative (Benchmark) Benefits Plans; private employers and nonfederal governmental plans with fewer than fifty-one employees who self-insure; grandfathered health plans offered on the individual market; large, self-funded nonfederal governmental health plans that opt out; and retiree-only plans (CCIIO 2016). Exemptions may change in light of debates ongoing at press time in the US Congress about the future of the ACA and the Medicaid program. Repeal of the ACA and changes to the Medicaid program could place the extension of MHPAEA protections to the individual and Medicaid insurance markets at risk.

about the challenges public officials and other stakeholders grapple with in the implementation of insurance parity.

Parity Policy and Regulatory Context

Access to treatment for MH/SUDs has historically been limited in the United States, in large part due to restrictive health insurance coverage that has offered substantially less generous benefits for MH/SUD services than for general medical services (Barry et al. 2003; Frank and Glied 2006). MH/SUD treatment advocates have therefore focused on the policy goal of equalizing insurance coverage between MH/SUD and general medical services. Their efforts led to a wave of legislation beginning in the 1990s that produced thirty-seven state MH/SUD parity laws and several federal parity laws. The most recent federal law, the 2008 MHPAEA, presents the prevailing opportunities and challenges in implementing nondiscriminatory insurance coverage of MH/SUDs in commercial and public health insurance markets today.

The MHPAEA is national in scope and extends to several insurance markets previously exempt from parity requirements. This, along with its strong parity mandate, makes it more comprehensive than most prior insurance parity laws. The MHPAEA requires parity for both in-network and out-of-network services, quantitative limits (cost sharing, dollar limits, and visit limits), and nonquantitative treatment limitations. Nonquantitative treatment limitations include medical management standards limiting or excluding benefits based on medical necessity; standards for provider admission to participate in a network; plan methods for determining usual, customary, and reasonable charges; fail-first policies or step therapy protocols; exclusions based on failure to complete a course of treatment; and formulary design for prescription drugs, among others. The MHPAEA also extends parity protections to SUD benefits if offered, which expands the reach of the majority of state laws and the 1996 Mental Health Parity Act beyond MH benefits. However, the MHPAEA does not define the conditions that qualify as MH/SUDs nor does it include an MH/SUD benefit mandate. It therefore leaves it to the discretion of the insurer to decide whether to offer MH/SUD benefits at all and which MH/SUD diagnoses are covered by the parity law (Barry, Huskamp, and Goldman 2010).[2]

2. Health plans subject to the MHPAEA may be subject to other insurance laws that incorporate MH/SUD benefits mandates. For example, in addition to extending the MHPAEA to plans offered on the Marketplaces, the ACA presently requires all Marketplace plans to cover MH/SUD services as essential health benefits. Similarly, some states mandate benefits for certain MH/SUD diagnoses, though the reach of such laws is typically limited to fully insured group plans.

Though the enactment of the MHPAEA is a striking achievement in this policy area, several challenges have marked its implementation and enforcement (Goodell 2015). First, although regulations issued by the Departments of Health and Human Services, Labor, and the Treasury have addressed some areas of uncertainty in interpretation of the statute, full implementation of the MHPAEA in private insurance markets was delayed until release of final rules in 2013, and noted areas of ambiguity remain. Interim regulations released in 2010 initially clarified requirements under the MHPAEA by establishing a framework for comparing MH/SUD and medical/surgical benefits by different benefits classifications (i.e., inpatient, outpatient, in- and out-of-network care, emergency care, and prescription drugs) and a quantitative approach to measuring the equivalence of financial requirements and quantitative limits placed on MH/SUD and medical/surgical benefits within each of these classifications. The interim rules also confirmed that parity standards would apply to the practices through which insurers manage the utilization, or limit the scope or duration, of benefits for services—that is, nonquantitative limits (US Department of the Treasury, US Department of Labor, and HHS 2010). This framework was largely retained in the final rule of 2013 (US Department of the Treasury, US Department of Labor, and HHS 2013). However, even while expanding the illustrative list of health plan standards and practices that would be subject to parity requirements for nonquantitative limits, the final rule does not offer general methods for how to measure and evaluate parity compliance in these areas.[3] The regulations call for comparability in the processes, strategies, evidentiary standards, and other factors used to apply nonquantitative limits to MH/SUD and medical/surgical benefits, with no more stringent application of these factors with regard to the MH/SUD benefits versus the medical/surgical benefits. Researchers have identified a number of considerations that stakeholders believe would complicate the operationalization of this parity standard for nonquantitative limits, including fundamental differences between MH/SUD and medical conditions, services, and providers (Ridgely, Pacula, and Burnam 2012). The potential for ambiguity around parity standards for nonquantitative limits, coupled with the delay in full regulatory implementation of the MHPAEA, has left a great deal of room for stakeholders to test

3. Examples of permissible and impermissible nonquantitative limits are provided in the final rule to demonstrate how parity applies to certain scenarios; however, the regulations do not cover all cases. A regulatory guidance released in June 2016 describes warning signs that a plan or issuer may be imposing an impermissible nonquantitative treatment limit. Still, the guidance does not specify the indicators relevant to conducting a full compliance analysis (US Department of the Treasury, US Department of Labor, and HHS 2016).

requirements under the MHPAEA through litigation. This litigation not only has the potential to reveal how the noted ambiguities are being framed but may also indicate where other, as yet unrecognized, ambiguities in the law still exist.

On top of these regulatory concerns, enforcement of the MHPAEA has been uneven. Oversight authority for the law is divided among several federal agencies and state insurance commissioners, whose bandwidth has been limited by the concurrent demands posed by health reform under the ACA. Though both federal and state agencies continue to issue regulatory guidance, active compliance monitoring and enforcement of the law has only been pursued in a handful of states. In many states, insurers self-certify that their products are parity compliant; in a few, state regulators have requested supporting evidence of compliance or committed to performing audits of health plans, and the attorneys general in California and New York are unique in launching large-scale investigations into MHPAEA violations by plans or issuers (Goodell 2015; Parity Implementation Coalition 2016). Advocates argue that consumers remain largely unaware of their rights to insurance parity or how their health plans are meeting parity requirements, which undermines the potential for enforcement via the markets (Firth, Kirzinger, and Brodie 2016). The research evidence supports a mixed picture of compliance. Several studies show an expansion in MH/SUD benefit generosity consistent with requirements of the MHPAEA following its enactment, specifically in reduced cost sharing and the imposition of visit and financial limits (Friedman 2016; Horgan et al. 2016). However, other studies suggest that issuers continue to offer plans that are inconsistent with the federal law, pointing to persistent disparities in cost sharing and the application of prior authorization to MH/SUD services (Berry et al. 2015; Goplerud 2013). These studies are limited in their capacity to directly observe compliance with parity standards for nonquantitative limits and therefore may overestimate true compliance.

In this context, private litigation has the potential to be both informative and influential in the effort to implement insurance parity via the MHPAEA. Generally speaking, in addition to litigation creating a body of case law through which courts directly interpret and enforce requirements, patterns in the topics under litigation also have the potential to mark where gaps in regulation or public enforcement mechanisms exist or where plaintiffs' expectations for legal protection might systematically differ from the specific content of a law (Parmet and Daynard 2000). In the case of parity-related litigation, if emergent patterns in the topics under litigation correspond to areas where regulatory or compliance monitoring efforts are

known to be sparse, or if they persist despite such efforts, they may highlight areas in which parity requirements are ripe for clarification or enforcement beyond the case-by-case resolution provided through the court system.

The MHPAEA is an important source of parity protections for virtually all commercially insured populations. It is also joined by parity laws in thirty-seven states to compose the full regulatory and enforcement context for insurance parity. Though we principally consider the relevance of litigation for implementing insurance parity via the MHPAEA, litigation pertaining to the state parity laws remains pertinent for two reasons. First, the MHPAEA does not preempt state parity laws. Instead, it serves as a coverage floor with respect to all existing and any future state parity laws. This means that the rights individuals can claim in a court still depend on how they are insured—and in some cases, where they live. State parity laws exhibit considerable heterogeneity in the legal protections they afford eligible populations. These protections depend on the diagnoses included in the statute (ranging from all conditions in the *Diagnostic and Statistical Manual of Mental Disorders* to only biologically based mental illnesses), specific requirements for coverage (e.g., mandated benefit, mandated if offered), and insurance parameters (e.g., cost sharing, deductibles, service limits). The enactment of the MHPAEA means that, in many cases, narrower state parity statutes may no longer dictate the MH/SUD parity requirements certain groups are covered under, while broader state parity statutes still apply. In this sense, litigation concerning state parity laws remains relevant to the implementation of insurance parity, particularly when the litigation pertains to components of state parity statutes that go beyond the coverage floor established by the MHPAEA. Second, considering the full body of case law enables an investigation into the types of issues consumers and stakeholders perceive in the historical effort to achieve nondiscriminatory insurance coverage of MH/SUDs. This may highlight potential points of controversy not yet litigated or decided for the relatively newer MHPAEA.

Private Litigation and Nondiscriminatory Insurance Coverage of MH/SUDs

In today's policy and regulatory context, legal claims to nondiscriminatory insurance coverage for MH/SUDs raise issues about the interpretation and enforcement of the MHPAEA and state parity laws. This litigation can be differentiated from an earlier effort by individuals to secure rights to nondiscriminatory coverage for MH/SUDs through the courts, which

preceded the period of parity legislative activity in the 1990s (Barrett 2008). In this prior period of litigation, individuals adversely affected by disparate MH/SUD and medical benefits in their health plans argued in court for more generous MH/SUD coverage in two ways. First, individuals who were denied coverage of their care under the MH/SUD benefit disputed insurers' classifications of their illnesses as mental versus physical health conditions, attempting to gain coverage under their plans' more generous general medical benefit. Though plaintiffs occasionally prevailed in these cases, this strategy proved largely unsuccessful (Barrett 2008). Moreover, insurers could easily avoid adverse legal outcomes by modifying their contracts to explicitly limit coverage for the disputed health conditions. The second strategy involved appeals to the nondiscrimination mandate in the Americans with Disabilities Act (ADA), under which enrollees in employer-sponsored health plans challenged disparate coverage of mental and physical conditions. This strategy was also unsuccessful in directly shaping MH/SUD insurance coverage, as courts consistently held that the ADA exempted from legal scrutiny the terms of health insurance plans when differential coverage was based on actuarial classifications of risk, versus specific mental disabilities (Farber 1994). It can be gathered from these patterns in the litigation that individuals' use of the courts in this prior period largely failed to redress their own complaints and had an indirect, if any, role in advancing the policy goal of achieving nondiscriminatory coverage of MH/SUDs (Barrett 2008).

Activity in the courts today differs in two ways from earlier litigation, which are relevant to our forthcoming analysis. First, the recent litigation that is the focus of this article is led by consumers seeking to clarify or enforce their rights in the context of insurance parity as the law of the land. The court system therefore joins policy, regulatory, and oversight apparatuses active in the task of monitoring and facilitating the implementation of nondiscriminatory insurance coverage of MH/SUDs, and the contribution of litigation to this policy goal must be interpreted against this background. By considering themes in litigation alongside the evolving regulatory and enforcement context, we identify where litigation reveals unique and unresolved challenges in the implementation of insurance parity. Second, the body of case law around insurance parity, and in particular the MHPAEA, is actively evolving. Therefore, our primary aim is not to assess the effects of this litigation in terms of policy outcomes. Instead, we focus on identifying themes in points and sources of controversy under the laws and the potential for this litigation to steer attention to challenges in the implementation of insurance parity. Our study is therefore situated in the

effort to understand how parity laws are being interpreted and applied on the ground, alongside literature that includes interviews of stakeholders, surveys of health plan representatives, and analyses of health plan benefits documents (Berry et al. 2015; Friedman 2016; Goplerud 2013; Horgan et al. 2016; Ridgely, Pacula, and Burnam 2012). Because litigation is used in practice to resolve remaining ambiguities and alleged wrongdoing under the laws, it has the advantage of providing a window through which difficult questions around the achievement of nondiscriminatory coverage for MH/SUDs can be examined.

Study Data and Methods

Data Sources and Searches

We conducted a comprehensive review of publicly available private legal challenges involving federal and state MH/SUD parity laws. Using the Westlaw legal research service, we searched for all cases from January 1, 1985, to December 8, 2015, concerning MH/SUD insurance parity using a search string based on common words in the titles of state and federal parity laws: *mental*, *mental health*, *addiction*, *substance use*, *substance abuse*, and *parity* ($N = 1{,}118$).[4] This query was run in a database containing all reported judicial opinions. However, it does not reach filings for which no initial decision has been reached (e.g., Amended Class Action Complaint, *Kamins v. UnitedHealthcare Insurance Co. of New York*, No. 064276/2014 [N.Y. Sup. Ct. filed Feb. 6, 2015]). Nor does it reach cases that are settled before they come before a judge (e.g., Complaint, *Katz v. Blue Cross of California et al.*, No. 2:2011cv00885 [Cal. C.D. Ct. filed Jan. 28, 2011]), the details of which are not reported in court documents and typically kept out of the public record. Our searches are therefore restricted to the subset of private legal actions that have entered the case law and for which details are available in the public record. For cases returning multiple records (e.g., several appellate decisions addressing the same cause of action), only the decision containing the final adjudication was retained.

Selection of Cases

Cases that were returned by our search but deemed irrelevant to our research question (i.e., having nothing to do with MH/SUD insurance parity) were

4. The first insurance parity laws were passed by North Carolina and Texas in 1991 (Robinson et al. 2006).

dropped from the sample ($N = 970$).[5] Four authors independently reviewed ten randomly selected cases from the remaining set to develop inclusion criteria for the final sample. It was noted during this process that the case law pertaining to state parity law was more developed than MHPAEA case law. This motivated the adoption of broad sample inclusion criteria in order to span the case law and align with our focus on examining topics under litigation, rather than necessarily the outcomes of the cases. Cases were included in the final sample if any of the legal claims advanced by the plaintiffs concerned a state or federal parity law. No restrictions were applied regarding the nature of the written opinion; that is, whether it concerned a procedural or substantive matter. For opinions that indicated the parity-related legal claim had been addressed in an earlier judicial opinion on the same cause of action, the earlier opinion was consulted for context. Cases mentioning a parity-related legal claim were excluded if the judicial opinion indicated that the plaintiff had dropped his or her parity-related claim in a prior proceeding. The lead author applied the inclusion/exclusion criteria and discussed cases that did not clearly meet these criteria with the research team. A quality control check was performed by cross-referencing the resultant sample with a publicly available list of parity-related cases prepared by the Legal Action Center in June 2015 for the Kennedy Forum. When inconsistencies were noted, they were resolved through discussion of the relevant cases with the research team.

Content Analysis and Synthesis

All cases were reviewed by two authors (KNB, CLB) to examine the primary substantive topic(s) at issue. We used a standardized data abstraction form to record key facts about each case, including the specific MH/SUD condition mentioned and details related to the alleged parity violation as well as the quantitative or nonquantitative treatment limits at issue, the statute pertaining to the parity claim (state vs. federal), the date of most recent or final adjudication, and holding in the case. Qualitative themes were extracted through review of the cases by the two independent reviewers based on consensus and then brought to the broader group of authors for discussion and review. In identifying themes, authors focused on the issues driving the legal dispute, specifically plaintiffs' or defendants' statements regarding their respective positions on the MH/SUD benefits owed. Where

5. Discarded cases included, for example, those in which the occurrence of the term *parity* referred to pregnancy or those in which legal claims pertained to disability income insurance benefits.

the judicial opinion included the court's reasoning about the relative merits of such statements, we considered this as well. (An alternative approach would have been to conduct an analysis of legal structural issues in cases in our sample, e.g., arguments regarding the proper use of the courts to dispute the benefits in question; however, our objective was instead to analyze cases through a policy lens.) Themes were extracted based on the review of all cases taken together; then, within each theme, legal claims were grouped based on whether they pertained to a state parity law versus the MHPAEA. Distinctions in how the disputes were framed and court reasoning within each theme were noted.

We synthesized evidence and present findings in two sections. First, we present basic statistics on the MH/SUD conditions and issues raised in insurance parity cases. Second, we describe six themes that emerged in the litigation relevant to policy with regard to insurance parity. We close with a discussion and implications for various actors involved in implementing and enforcing insurance parity.

Findings

Identification and Description of Cases

Our final sample included thirty-seven cases, with decisions dating from 2005 through 2015 (table 1). In all cases, plaintiffs (e.g., enrollees in health plans) alleged that relevant parties (e.g., insurers, firms) unfairly scrutinized or rejected plaintiffs' MH/SUD claims or failed to pay for proper MH/SUD benefits in violation of the MHPAEA ($N=7$), a state parity law ($N=26$), or both ($N=4$). Claims advanced under state parity laws were clustered in certain states; the state with the greatest number of cases was California (eleven cases), followed by Washington and New Jersey (five cases each).

Specific MH/SUD Conditions, Coverage Exclusions, and Benefit Limits at Issue in Cases

Table 2 summarizes specific diagnoses, coverage exclusions, and benefit limits at issue in these cases. Plaintiffs alleged parity violations related to insurance benefits for the treatment of autism spectrum disorders (ASD) or other developmental disorders in thirteen cases, for the treatment of an eating disorder in eleven cases, and for an unspecified MH/SUD condition in thirteen cases.

Table 1 Thirty-Seven Cases Brought under the Mental Health Parity and Addiction Equity Act of 2008 and/or State Parity Laws, with an Initial Level of Decision, 2005–2015

Case	MHPAEA	State Parity Law	Last Ruling Date
Raquel F. v. United Healthcare Insurance Company, No. 15-cv-00879, slip op. (N.D. Cal. Nov. 30, 2015)		CA	Nov. 2015
Tedesco v. I.B.E.W. Local 1249 Ins. Fund, No. 14-cv-3367, slip op. (S.D.N.Y. Oct. 28, 2015)	x		Oct. 2015
O'Dowd v. Anthem Health Plans, Inc., No. 14-cv-02787, slip op. (D. Colo. Sept. 30, 2015)		CO	Sept. 2015
New York State Psychiatric Ass'n v. United Health Group, 798 F.3d 125 (2d. Cir. 2015)	x		Aug. 2015
Craft v. Health Care Serv. Corp., 84 F.Supp.3d 748 (N.D. Ill. 2015)	x		Mar. 2015
K. M. v. Regence Blue Shield, No. C13-1214, slip op. (W.D. Wash. Feb. 9, 2015)	x	WA	Feb. 2015
O. S. T. ex rel. G. T. v. Blue Shield, 335 P.3d 416 (Wash. 2014)		WA	Oct. 2014
American Psychiatric Ass'n v. Anthem Health Plans, 50 F.Supp.3d 157 (D. Conn. 2014)	x		Sept. 2014
R. H. v. Premera Blue Cross, No. C13-97, slip op. (W.D. Wash. July 7, 2014)		WA	Aug. 2014
A. F. ex rel. Legaard v. Providence Health Plan, 35 F.Supp.3d 1298 (D. Or. 2014)	x	OR	Aug. 2014
Daniel F. v. Blue Shield of California, 305 F.R.D. 115 (N.D. Cal. 2014)		CA	Aug. 2014
Rea v. Blue Shield of California, 172 Cal.Rptr.3d 823 (Cal. Dist. Ct. App. 2014)		CA	June 2014
Consumer Watchdog v. Dep't of Managed Health Care, 170 Cal.Rptr.3d 629 (Cal. Dist. Ct. App. 2014)		CA	Apr. 2014
Brazil v. Office of Pers. Mgmt., 35 F.Supp.3d 1101 (N.D. Cal. 2014)	x	CA	Mar. 2014

(*continued*)

Table 1 Thirty-Seven Cases Brought under the Mental Health Parity and Addiction Equity Act of 2008 and/or State Parity Laws, with an Initial Level of Decision, 2005–2015 (*continued*)

Case	MHPAEA	State Parity Law	Last Ruling Date
Smith v. U.S. Office of Personnel Management, 80 F.Supp.3d 575 (E.D. Pa. Feb. 26, 2014)	x		Feb. 2014
Jarman v. Capital Blue Cross, 998 F.Supp.2d 369 (M.D. Pa. 2014)	x		Feb. 2014
Z. D. ex rel. J. D. v. Group Health Co-op, No. C11-1119, slip op. (W.D. Wash. Feb. 5, 2014)		WA	Feb. 2014
Schoolman v. United Healthcare Ins. Co., No. 4:13CV282, slip op. (E.D. Mo. Dec. 18, 2013)		NY, MO	Dec. 2013
Doe v. Trustees of Indiana University, No. 1:12-CV-1593, slip op. (S.D. Ind. July 3, 2013)	x	IN	July 2013
J. T. v. Regence BlueShield, 291 F.R.D. 601 (W.D. Wash. 2013)		WA	June 2013
Harlick v. Blue Shield of California, No. C 08-3651, slip op. (N.D. Cal. June 3, 2013)		CA	June 2013
C. M. v. Fletcher Allen Health Care Inc., No. 5:12-CV-108, slip op. (D. Vt. Apr. 30, 2013)	x		Apr. 2013
B. C. v. Blue Cross of California, No. CV 11-08961, slip op. (C.D. Cal. Jan. 3, 2012)		CA	Jan. 2012
Burton v. Blue Shield of California Life and Health Ins. Co., No. CV 10-09581, slip op. (C.D. Cal. Jan. 12, 2012)		CA	Jan. 2012
Edgar v. MVP Health Plan Inc., No. 1:09-CV-700, slip op. (N.D. N.Y. May 9, 2011)		NY	May 2011
Douglas S. v. Altius Health Plans Inc., 409 Fed.Appx. 219 (10th Cir. 2010)		UT	Nov. 2010
J. S. v. State Health Benefits Comm'n, 2010 WL 770978 (N.J. Super. Ct. App. Div. Mar. 4, 2010)		NJ	Mar. 2010
Jon N. v. Blue Cross Blue Shield of Massachusetts, 684 F.Supp.2d 190 (D. Mass. 2010)		MA	Feb. 2010

Table 1 (*continued*)

Case	MHPAEA	State Parity Law	Last Ruling Date
Arce v. Kaiser Found. Health Plan Inc., 104 Cal.Rptr.3d 545 (Cal. Ct. App. 2010)		CA	Jan. 2010
Beye v. Horizon Blue Cross Blue Shield of New Jersey, 568 F.Supp.2d 556 (D. N.J. 2008)		NJ	Aug. 2008
DeVito v. Aetna Inc., No. 07-00418, slip op. (D. N.J. June 25, 2008)		NJ	June 2008
Wedekind v. United Behavioral Health, No. 1:07-CV-26, slip op. (D. Utah Jan. 24, 2008)		NE	Jan. 2008
Wayne W. v. Blue Cross of California, No. 1:07-CV-00035, slip op. (D. Utah November 1, 2007)		CA	Nov. 2007
Micheletti v. State Health Benefits Comm'n, 913 A.2d 842 (N.J. Super. Ct. App. Div. 2007)		NJ	Jan. 2007
Markiewicz v. State Health Benefits Comm'n, 915 A.2d 553 (N.J. Super. Ct. App. Div. 2007)		NJ	Jan. 2007
Thompkins v. BC Life and Health Ins. Co., 414 F.Supp.2d 953 (C.D. Cal. 2006).		CA	Jan. 2006
Daley v. Marriott Intern Inc., 415 F.3d 889 (8th Cir. 2005)		NE	July 2005

Source: Cases were identified using Westlaw legal research service.

In twenty-five cases in our sample, plaintiffs alleged that exclusions of certain types of MH/SUD services from health plan coverage represented a violation of parity laws. Six of these cases pertained to the MHPAEA, and twenty-three pertained to a state parity law (categories not mutually exclusive). Among these, coverage exclusions related to certain settings of treatment (e.g., residential treatment) were at issue in fourteen cases; coverage exclusions relating to certain types of treatments (e.g., neurodevelopmental therapy) were at issue in nine cases; and coverage exclusions for services when they were provided by certain types of providers (e.g., providers of applied behavioral analysis to treat ASD) were at issue in four cases.

Table 2 Specific MH/SUD Conditions, Coverage Exclusions, and Benefit Limits at Issue in Parity Cases

	Cases Pertaining to the MHPAEA	Cases Pertaining to a State Parity Law	Total Cases
Diagnoses at issue			
Autism spectrum/developmental disorders	3	12	13
Eating disorders	2	10	11
Other MH/SUD and condition not specified	6	8	13
Methods of limiting treatment at issue[a]			
Coverage exclusions	6	23	25
Insurance benefit not offered for certain settings of care (e.g., residential treatment)	4	12	14
Insurance benefit not offered for certain services (e.g., neurodevelopmental therapies)	2	9	9
Insurance benefit not offered for certain providers (e.g., providers of applied behavior analysis)	—	4	4
Limits on covered benefits	5	8	13
Financial and visit limits on MH/SUD benefit	1	1	2
Medical necessity determinations	3	6	9
Provider reimbursement policies	1	1	2
Exclusion of MH/SUD from protection under parity law (i.e., nonbiologically based mental illness)	—	3	3

[a]Multiple treatment limits may be at issue within the same case; total cases do not sum to thirty-seven.

In thirteen cases in our sample, plaintiffs alleged that certain limits on covered benefits represented a violation of parity laws. Five of these cases pertained to the MHPAEA, and eight pertained to a state parity law. Of these, two cases involved quantitative limits on covered benefits. In both cases, plaintiffs alleged that health plans imposed stricter outpatient visit limits and annual financial limits on MH/SUD benefits compared with general medical benefits. In nine cases, plaintiffs challenged the limits on MH/SUD services imposed by health plans through their assessment and determination of the medical necessity of a treatment episode. In two cases, plaintiffs alleged that health plans improperly limited covered MH/SUD

benefits by setting more restrictive reimbursement rates for MH/SUD services than for general medical services.

Lastly, three cases in the sample occurred in states whose parity laws only extend parity protections to biologically based mental illnesses. In these cases, plaintiffs disputed whether a certain condition (i.e., developmental disorder, eating disorder) should be deemed biologically based or not.

Themes in Litigation Reflecting Areas of Uncertainty or Controversy

We identified six themes in our review of parity case law that reveal some of the main areas of uncertainty and/or controversy in the implementation of parity statutes. Four themes, presented in table 3, relate to disputes on how parity applies to certain features of health insurance coverage. Two themes, presented in table 4, relate to disputes on how parity laws interact with other laws—and their own implementing regulations—to regulate MH/SUD insurance. For each of the six themes, we note the core issue, a specific case in which it was raised, and language excerpted from that case illustrating the discourse regarding it. We contextualize the theme in the regulatory environment where relevant.

Theme 1: Scope of Services Guaranteed under Parity Laws. First, we identified a recurring dispute in litigation related to the scope of services guaranteed under parity. *Scope of services* generally refers to treatment settings and treatment types that a health plan covers. A specific area of ambiguity in the case law concerned the application of parity to the residential treatment of MH/SUD conditions. This was raised in twelve cases pertaining to state parity laws and four cases pertaining to the MHPAEA (table 2). Plaintiffs in these cases challenged the categorical exclusion of residential treatment from coverage under their plans, which resulted in denials of coverage for the treatment of eating disorders and SUDs in nonhospital residential facilities.[6] For example, in *Harlick v. Blue Shield of California* (No. C 08-3651, slip op. [N.D. Cal. June 3, 2013]), a high-profile case decided in California in 2012, a so-called residential coverage exclusion in Harlick's plan resulted in denial of residential treatment for her anorexia nervosa. Harlick alleged that this violated a mandate in the

6. Excluding categories of benefits from plan coverage implies that such benefits are not available to any enrollee in the plan, regardless of medical necessity. This differs from an insurance practice in which a health plan covers a category of benefits (e.g., residential treatment), but only enrollees for whom the treatment is deemed medically necessary can claim benefits. The former practice, not the latter, is at issue in these cases.

Table 3 Themes in Insurance Parity Litigation, with Illustrative Cases

Theme	Issue in Litigation	Illustrative Case	Excerpt
Scope of services guaranteed under parity	Coverage exclusions of residential treatment	*Craft v. Health Care Service Corp.*, 84 F.Supp.3d 748, 749–50 (N.D. Ill. 2015)	"HCSC denied [plaintiff] Craft's request to preauthorize [residential treatment center (RTC)] treatment pursuant to . . . 'the RTC exclusion.' . . . There is no corresponding exclusion for treatment of medical and surgical conditions in similar residential facilities. The plaintiffs claim that this exclusion violates [federal MHPAEA] provisions . . . requiring parity between mental-health and medical/surgical benefits."
Nature of therapies covered for treatment of mental disorder	Coverage exclusions of nonrestorative therapies and educational and developmental services	*Micheletti v. State Health Benefits Com'n*, 913 A.2d 842, 850 (N.J. Super. Ct. App. Div. 2007)	"Denial of coverage for Jake's prescribed treatment is couched in terms of the contractual exclusion of benefits for non-restorative speech, physical and occupational therapy, but . . . the therapy is the only treatment modality for an autistic child. Denial of the treatment amounts to exclusion from coverage of a class of dependents, notably afflicted children, based on the nature of their mental illness . . . thereby excluding autism from coverage despite the legislative directive to the contrary in [New Jersey] Mental Health Parity Law."

Table 3 (*continued*)

Theme	Issue in Litigation	Illustrative Case	Excerpt
Credentialing standards for providers of MH/SUD services	Coverage exclusions of services (e.g., applied behavior analysis) provided by unlicensed individuals	*Consumer Watchdog v. Dept. of Managed Health Care*, 170 Cal.Rptr.3d 629, 647 (Cal. Dist. Ct. App. 2014)	"Consumer Watchdog alleged that, by failing to compel plans . . . to provide coverage for [applied behavioral analysis] therapy provided or supervised by an unlicensed but [Behavior Analyst Certification Board]-certified practitioner, [California Department of Managed Health Care] 'ha[d] violated, and will continue to violate, [its] clear, present, and mandatory duty' to enforce . . . the [California Mental Health Parity Act]."
Processes for determining medical necessity	Limits on covered benefits set by definition of medical necessity, prior authorization, concurrent review	*C. M. v. Fletcher Allen Health Care Inc.*, No. 5: 12–CV-108, slip op. at 5 (D. Vt. Apr. 30, 2013)	"Plaintiff alleges that Fletcher Allen violated the [federal] Parity Act by imposing . . . more stringent reviews for mental health benefits than are imposed for medical benefits. . . . She alleges that [mental health benefit claims administrator] conducts prospective and concurrent medical necessity reviews of routine . . . mental health office visits while [medical benefit claims administrator] conducts no such reviews for comparable medical office visits."

California parity law that required coverage for all "medically necessary treatment" of "severe mental illnesses," including anorexia nervosa, and prevailed in her claim. Subsequent litigation around this issue in California has sought, successfully, to enforce the requirement. Interestingly, since California's parity law includes a benefit mandate, the court resolved the case without comparing Harlick's MH/SUD benefits to some standard set by the general medical benefits covered under her plan. This has not been the case in residential treatment-related litigation pertaining to the MHPAEA, which does not include a benefit mandate. For example, when a residential coverage exclusion was challenged in *Craft v. Health Care Service Corporation* (84 F.Supp.3d 748 [N.D. Ill. 2015]) (table 3), an Illinois district court considered the comparability of the plan's coverage for MH/SUD and medical treatment settings to be relevant to resolving the case. Coverage would not be at parity, the court suggested, if the exclusion of treatment in a nonhospital residential facility was a limitation that applied solely to MH/SUD services.

Although residential settings of treatment have been the focus of litigation, they are only one type of so-called intermediate level services for the treatment of MH/SUDs. These are services that fall between traditional inpatient and outpatient care, such as nonhospital residential treatment, partial hospitalization, and intensive outpatient treatment. Health plans subject to the MHPAEA were directed in the interim rules implementing the law to assign benefits for these services, if they were covered, to benefits classifications in a manner consistent with the method of assigning benefits for covered medical services (US Department of the Treasury, US Department of Labor, and HHS 2010). However, MHPAEA-related litigation is picking up an issue distinct from this "consistent assignment" directive—plaintiffs, including Craft, dispute the permissibility of plans excluding coverage for certain intermediate-level services altogether. This controversy in the courts, around whether and how an MHPAEA parity standard applies to coverage exclusions of intermediate-level services, corresponds with an early gap in regulations that was later addressed in the MHPAEA final rule. There, it was clarified that such coverage exclusions are to be treated as nonquantitative limits, subject to the nonquantitative parity standard.[7] This theme in litigation therefore connects to a dispute

7. The agencies initially abstained from clarifying this "scope of services" issue in the interim rules and only addressed it later in the final rule. Specifically, the final rule stated that any coverage exclusions impacting the provision of MH/SUD care in certain facility types (e.g., nonhospital residential care facilities) must meet the parity standard for nonquantitative limits by being based on processes and standards comparable to and no more stringently applied than those used to exclude certain types of medical facilities (e.g., skilled nursing facilities) (US Department of the Treasury, US Department of Labor, and HHS 2013).

that has since been partially resolved outside the court system, though it remains to be seen both in the litigation we reviewed and in regulation how compliance with such a standard will be evaluated.

Theme 2: Nature of Therapies Covered. Another theme that emerged in our review concerns the coverage of services that were considered by health plans to be nonrestorative, nonhealthcare, educational, or developmental in nature. Disputes around the application of parity to services of this nature occurred in nine cases pertaining to state parity laws and two cases pertaining to the MHPAEA (table 2). Health plans in these cases had categorically excluded coverage for services that fell under one or more of these headings. Plaintiffs alleged that these exclusions violated parity when they resulted in denials of coverage for therapies that are often used to manage behavioral and functional deficits resulting from ASD and other neurodevelopmental disorders, including applied behavioral analysis (ABA) and speech-language, occupational, and physical therapies. For example, in *Micheletti v. State Health Benefits Commission* (913 A.2d 842, 846 [N.J. Super. Ct. App. Div. 2007]), the commission responsible for administering New Jersey's public employee health benefits program applied a "nonrestorative exclusion" in its health plan to exclude from coverage services intended "to promote development beyond any level of function previously demonstrated"—including speech and occupational therapy that would treat autism in Micheletti's son. Micheletti looked to the New Jersey parity law to challenge the coverage exclusion and prevailed in his claim for coverage to include these therapies (table 3).

In *Micheletti*, and in the majority of cases pertaining to state parity laws, the disputed coverage exclusions affected benefits for the treatment of both mental and physical developmental disorders. Insurers argued that since these exclusions applied to both MH/SUD and general medical services, they did not violate parity requirements. The courts have not favored this argument when considering the requirements of state parity laws, finding instead that these exclusions either violated mandated mental health benefits provisions in state parity laws or, as in *Micheletti*, had the perverse effect of denying coverage for the principal medically necessary services for a diagnosis—autism—that the insurer was required to cover. When it comes to the MHPAEA, however, there is no benefits mandate, and the diagnoses covered are left to the discretion of the insurer. Thus, when nonrestorative or developmental exclusions are challenged in MHPAEA cases, the standard insurers' defense at the state level (i.e., that the disputed exclusions apply equally to benefits for the treatment of both mental and physical developmental disorders) may find greater favor. Of the two cases

in our sample in which such exclusions were challenged as violations of the MHPAEA, only one, *AF ex rel Legaard v. Providence Health Plan* (35 F.Supp.3d 1298 [D. Or. 2014]), had reached its final adjudication—with a decision in favor of the plaintiff. In this case, however, the disputed developmental exclusion only applied to therapies for neurodevelopmental (not physical) disorders, differentiating it from the rest of the cases that fall into this theme. It therefore remains to be seen whether the defense described above would pass scrutiny under federal law when these types of coverage exclusions affect therapies for both mental and physical developmental disorders. If it did, it might permit significant limits for therapies that predominantly treat serious mental health conditions such as ASD. The issue under litigation here—that is, how parity regulates coverage of standard treatments for neurodevelopmental disorders when they are subsumed under benefit labels (e.g., nonrestorative) that are subject to general limitations—has not received regulatory attention under the MHPAEA. This controversy is also salient for other coverage exclusions used in health plans that relate to the nature of a therapy, such as exclusions of therapies deemed experimental or investigative. These other types of exclusions have not yet been disputed in parity litigation, though insofar as they would disproportionately affect MH/SUD services, cases of a similar structure to those discussed here may emerge.

Theme 3: Credentialing Standards for Providers of MH/SUD Services. A third theme relates to insurers' credentialing of providers of MH/SUD services. MH/SUD providers can have widely different levels and types of training and may hold credentials that are regulated differently than those in the general medical arena (Ridgely, Pacula, and Burnam 2012). This creates a challenge for managing provider networks, in which insurers assess the training, experience, and licensure of providers as part of a credentialing process. The credentialing standards adopted by insurers may affect whether covered services will be reimbursed (based on who provided them) and whether certain services are covered under the terms of a health plan (based on the credentials of their standard providers). Four cases in our sample involved disputes over insurers incorporating state provider licensing regulations into coverage determinations and their impact on plan coverage for therapies that treat neurodevelopmental disorders (e.g., ABA and speech-language, occupational, and physical therapy). All pertained to state parity laws (table 2).

For example, in *Consumer Watchdog v. Department of Managed Health Care* (170 Cal.Rptr.3d 629 [Cal. Dist. Ct. App. 2014]), an advocacy group challenged a determination by California's state regulator of health plans

that coverage would not be required for ABA therapy to treat ASD when performed by providers who did not hold a license to practice medicine or psychology in the state. The advocacy group argued that therapists who do not meet this credentialing standard are the customary providers of ABA therapy. Permitting health plans to require a state license as part of their credentialing process, they argued, would effectively exclude ABA therapy from coverage under the plans—allegedly conflicting with health plans' legal obligation to cover the "medically necessary treatment of severe mental illnesses" under California's parity law (California Health and Safety Code §1374.72, subd. [a]). The advocacy group further argued that unlicensed providers of ABA therapy hold relevant certifications from a private national credentialing organization (the Behavior Analyst Certification Board). In a second example in Washington state, *O. S. T. ex rel G. T. v. Blue Shield* (335 P.3d 416 [Wash. 2014]), the insurer claimed that since functional therapies for the treatment of neurodevelopmental disorders could be administered by providers who did not meet state licensing requirements for mental health practitioners, these therapies were not "mental health services" in nature, were thus exempt from Washington's parity protections, and could be limited at the insurer's discretion. In contrast, the plaintiffs in this case—the parents of the child denied coverage of his functional therapy—contended that provider qualifications do not bear on the therapy's classification as treatment for a mental health condition and its protection under Washington's parity law. In each of these cases, the courts decided that the insurers' use of licensing requirements to restrict mental health benefits conflicted with their respective state parity laws. Following *Consumer Watchdog*, subsequent regulations were issued in California codifying the court's interpretation of this issue.

This issue has not yet been raised in the courts with regard to the MHPAEA. There is a federal regulation permitting that parity-compliant credentialing processes (i.e., consistency in the application of training, experience, and licensure standards to MH/SUD and general medical providers) may nonetheless have a disparate impact on MH/SUD providers (US Department of the Treasury, US Department of Labor, and HHS 2013). However, what the litigation at the state level highlights is how credentialing processes can affect not just providers but also benefits for the MH/SUD services covered under a plan. The issue here—that is, how parity applies to provider credentialing when the standards adopted may affect the definition of MH/SUD benefits (and thus whether they are subject to parity requirements) or access to these benefits under a plan—is an as-yet-unaddressed dimension of credentialing processes that regulators of the MHPAEA may consider.

Theme 4: Processes and Standards for Determining the Medical Necessity of MH/SUD Services. Another area of controversy that emerged in our review of cases is the application of parity to determinations of medical necessity. *Medical necessity* generally refers to the appropriateness of a specific treatment or course of care for a specific patient, the precise definition of which is laid out in a health plan contract. Typically, for an intervention to be covered for an individual beneficiary it must be an otherwise covered category of service under the terms of the health plan and meet the plan's criteria for medical necessity. These criteria and the manner in which they are applied may limit coverage of MH/SUD services, which is the subject of litigation in nine cases in our sample (table 2).

In medical necessity litigation pertaining to the MHPAEA ($N = 3$ cases), plaintiffs alleged that health plans and insurers applied stricter processes or standards for determining the medical necessity of MH/SUD services than they applied to general medical services. For example, in 2013's *C. M. v. Fletcher Allen Health Care Inc.* (No. 5:12-CV-108, slip op. [D. Vt. April 30, 2013]), the plaintiff challenged the use of prospective and concurrent medical necessity reviews for her routine mental health office visits, when her insurer did not require similar reviews for routine medical office visits (table 3). In 2015's *New York State Psychiatric Association Inc. v. UnitedHealth Group* (798 F.3d 125 [2d. Cir. 2015]), several individuals denied coverage for their mental health care, together with a professional association of psychiatrists, asserted that their claims administrator violated the MHPAEA by using internally developed criteria to define medical necessity for MH/SUD services that were allegedly more strict than the industry standard criteria used for general medical services.

Though these MHPAEA cases have not yet been decided on their merits, they represent an interesting development in the process of making medical necessity determinations under federal parity compared to state parity. In state parity cases ($N = 6$), the courts would defer to insurer judgments regarding the medical necessity of a service unless evidence suggested the insurer had abused its discretion in the matter—for example, if a financial conflict of interest existed. Under the MHPAEA, the courts now focus their review on whether the processes (e.g., concurrent review) and standards (e.g., the criteria for demonstrating medical necessity) that insurers use to determine the medical necessity of MH/SUD treatment are comparable to and applied no more stringently than those used to determine the medical necessity of general medical services. This approach, which mirrors the regulatory guidance issued to implement the MHPAEA, in effect replaces

insurer "discretion" with distinct processes and standards that may be scrutinized in the courts when MH/SUD benefits are denied on these grounds.

The formalization of this process under the MHPAEA also brings with it new evidence requirements for the courts to assess parity in medical necessity determinations. Such evidence has included, in the cases in our sample, specifics on a health plan's processes and standards for determining medical necessity and how they were developed and have been applied to MH/SUD and general medical benefits—information that a plan enrollee may struggle to acquire at the outset of a legal claim. In a 2013 decision, *C.M. v. Fletcher Allen Health Care Inc.*, a Vermont federal district court eased this evidentiary burden for potential plaintiffs making medical necessity parity claims in court. Specifically, the court refused to dismiss a woman's suit alleging that her health plan had applied stricter processes for assessing the medical necessity of psychotherapy versus general medical services, despite the insurer's argument that the woman had failed to show that any such differences were not justifiable. This decision has the implication that insurer defendants, and not individual plaintiffs, bear the burden of proving that no difference exists in the application and content of medical necessity criteria for MH/SUD and general medical benefits, or that any difference observed is justified. This development is likely to facilitate additional litigation around medical necessity. Still up for debate in these cases is how evidence presented by health plan enrollees and health plans will be evaluated to prove the comparability (or lack thereof) of medical necessity determinations in mental health and general medical areas. Going forward, the evidence brought by insurers in specific cases and court judgments may usefully inform compliance-monitoring efforts at the population level.

Theme 5: Intersection of Parity and Other Insurance Laws. Our review of relevant litigation also revealed disputes around features of the statutory and regulatory landscape that affect the enforcement of state and federal parity laws (table 4). We identified five cases that resulted from ambiguity around how state and federal parity laws interact with other insurance laws, such as state autism insurance mandates, developmental disability mandates, and provider licensing laws, to regulate MH/SUD benefits. In these cases, insurer defendants contended that their coverage of MH/SUD benefits met requirements set by nonparity insurance laws and that these laws also governed the relevant benefits. The issue was raised in 2014's *Jarman v. Capital Blue Cross* (998 F.Supp.2d 369 [M.D. Pa. 2014]) (table 4),

Table 4 Features of Statutory and Regulatory Landscape Affecting Enforcement of Parity Law, with Illustrative Cases

Theme	Issue in Litigation	Illustrative Case	Excerpt
Intersection of parity and other insurance laws	State autism insurance mandates, state developmental disability insurance mandates, state licensing laws	*Jarman v. Capital Blue Cross*, 998 F.Supp.2d 369, 373 (M.D. Pa. 2014)	"As part of his [autism spectrum disorder] treatment, Jarman receives applied behavior analysis ("ABA") services … the Health Plan contractually agreed to reimburse ABA services up to the $36,000 annual dollar limit established by the Pennsylvania Autism Insurance Act ("Act 62") … Plan does not impose annual or lifetime dollar limits with respect to medical or surgical benefits … Jarman contends that [federal MHPAEA] preempts and supersedes the application of Act 62's annual dollar amount limitation to his claims for ABA benefits."
Intersection of parity statutes and related regulatory actions	Enforcement of scope of service provisions prior to release of Final Rule implementing MHPAEA	*Craft v. Health Care Service Corp.*, 84 F.Supp.3d 748, 754 (N.D. Ill. 2015)	"If the Departments had resolved the 'scope of services' issue in the [interim final regulations]—either in favor of, or against, coverage—the court would have had to decide whether, or to what extent, their interpretation was entitled to deference. But they did not resolve the issue. So, the court still must decide whether HCSC violated the [federal] Parity Act when it enforced the [residential treatment center] exclusion to deny Craft's preauthorization request … before the final regulations became effective."

in which the insurer only reimbursed plaintiff Jarman's claims for ABA therapy to treat his autism up to the $36,000 annual amount required by the Pennsylvania Autism Insurance Act. Though the plan's general medical benefit had no comparable annual dollar limits, Jarman's insurer argued that the terms of its plan were permissible unless and until the state department of insurance indicated how the MHPAEA would interact with the state's autism insurance act. This case has not yet been decided on its merits. Perceived statutory conflict of this kind is not unique to parity law, but litigation of this nature reflects a complexity in the underlying health insurance statutory landscape that can undermine parity compliance.

Theme 6: Intersection of Parity Statutes and Related Regulatory Actions. We identified seven cases in which the dispute around parity requirements arose from perceived inconsistencies between parity policy (i.e., statutes), the content of regulations implementing parity, and the actions of government agencies responsible for enforcing parity. In a representative case, *Markiewicz v. State Health Benefits Commission* (915 A.2d 553 [N.J. Super. Ct. App. Div. 2007]), the state agency responsible for implementing and monitoring parity in New Jersey's State Health Benefits Program permitted coverage exclusions for neurodevelopmental therapies, which plaintiffs contended contradicted New Jersey's parity law. A New Jersey appellate court agreed with the plaintiffs and ordered the agency to enforce coverage consistent with the court's interpretation of the policy underlying the law. This pattern played out in five other cases pertaining to state parity laws in our sample.

Again, such conflicts are not unique to parity policy; however, litigation of this nature shows the direct role that the courts have played in advancing an interpretation of parity law that is not otherwise being promulgated or enforced by the relevant government agencies. This is particularly salient with regard to the MHPAEA, the implementation of which has been complicated by a five-year delay between its effective date and the release of its final regulations. A 2015 case, *Craft v. Health Care Service Corporation*, highlights the challenge: here, the insurer defended a residential coverage exclusion in its plan by claiming that it was only in effect during a period in which interim rules implementing the MHPAEA deliberately left unresolved how federal parity would apply to the coverage of intermediate services. The court held that the MHPAEA was "self-implementing" and that it would be within the bounds of the law to find the insurer liable for enforcing its residential treatment exclusion even before final MHPAEA regulations clarified the issue and became effective (table 4). The decision suggests that even insurers complying with existing regulations may face

legal risk. The expansiveness of the MHPAEA's parity mandate, as well as the inherent challenge in promulgating rules and guidance to cover every possible MH/SUD benefit scenario, amplify this risk to insurers. Regulatory attention to the major parity issues subject to legal action may mitigate this risk and deter risk-averse insurers from potentially dropping coverage of MH/SUD benefits altogether.

Discussion

Our investigation of the private litigation around parity laws has focused on what the cases taken together reveal about areas of uncertainty and dispute related to the implementation and enforcement of parity. Our findings indicate that the primary substantive topics at issue in this litigation mirror the issues that have come up in MH/SUD policy discourse. These include the scope of services guaranteed by parity laws, the coverage of specific therapies, the credentialing standards for MH/SUD providers, and the processes and standards for determining the medical necessity of MH/SUD services. We also find that in the majority of cases, plaintiffs turned to the courts to claim benefits for the treatment of ASD, other developmental disorders, or eating disorders. The frequency with which these diagnoses appear in litigation signifies considerable uncertainty over how state and federal parity protections apply to services for these disorders, especially high-intensity services (e.g., ABA therapy and residential treatment) that have historically been excluded or limited in commercial health insurance (Peele, Lave, and Kelleher 2002; Garfield, Lave, and Donohue 2010). Finally, our findings indicate that the implementation of parity has been complicated by uncertainty about how state and federal parity laws interact with existing insurance laws and by disputes around the coherence of policy, implementing regulations, and monitoring and enforcement actions by government agencies. Litigation around these issues has highlighted the courts' capacities to interpret key parity provisions—the potential impact of which on broader parity policy is uncertain.

The MHPAEA is more comprehensive in most respects than earlier state parity laws, due in part to its extension of parity requirements to nonquantitative limits. However, litigation reveals that there has been considerable controversy around these provisions of the law. Plaintiffs challenged a range of insurance practices as potential violations of the MHPAEA's parity requirements in nonquantitative limits, including exclusions of coverage for residential treatment and ABA therapy and medical necessity determinations. The repeated attention to these issues through

litigation suggests that plaintiffs have experienced barriers to the realization of rights under the laws or plaintiffs' expectations of their rights to certain benefits under parity have been inapposite. With regard to the former, such barriers may include gaps or delays in regulations or in public enforcement of the MHPAEA, as discussed above. For certain themes we identified in the litigation, regulations have since addressed some of the topics under dispute. Specifically, regulations issued in the final rule implementing the MHPAEA have clarified the standard by which exclusions of coverage for nonhospital residential treatment of MH/SUDs would be assessed and have established a presumption of impermissibility for such blanket exclusions in an environment where insurance coverage of nonhospital residential treatment for medical conditions is standard. The regulations also clarified that the permissibility of determinations of the medical necessity of MH/SUD services would depend in part on the comparability of criteria used to gauge whether MH/SUD and medical/surgical services are medically necessary and the processes by which plans review services for concordance with these criteria. Though issuance of these regulations has reduced some of the uncertainty that the litigation we discuss had sought to resolve, there remains ambiguity in a key component of these cases as they make their way through the courts: specifically, how the comparability of coverage exclusions and medical necessity determinations for MH/SUD and medical/surgical benefit areas will be evaluated. This issue—that is, how to demonstrate compliance with parity standards for nonquantitative limits, is an ongoing gap in the enforcement of parity that seems yet to be resolved either through the courts or in public compliance-monitoring efforts.

For certain other themes identified in the litigation, the topics under dispute are not directly addressed by any MHPAEA regulation. Exclusions of coverage for ABA therapy, based on its classification as "nonrestorative" or "developmental" by some plans, are hotly disputed in the courts, suggesting that a lack of understanding about what the law requires in this area is an ongoing challenge for the implementation of parity laws. And while there is an MHPAEA regulation concerning the potential impacts of parity-compliant provider credentialing processes on providers of MH/SUD services, this does not address the topic disputed in litigation at the state level—that is, the permissibility of credentialing processes that would affect benefits for MH/SUD services. Both these areas may benefit from a greater understanding about what the MHPAEA requires, a process that could unfold via additional litigation or through the attention of regulators working to head off these controversies.

Importantly, advocates have noted potential barriers to the enforcement of parity in nonquantitative limits through the courts. Pursuing a legal challenge to these nonquantitative limits requires potential plaintiffs to access and understand their insurers' practices in designing MH/SUD and general medical benefits, which is undermined by a lack of transparency in the industry around practices and processes considered proprietary. Potential plaintiffs may also have limited insight into whether the barriers to treatment they encounter reflect disparities in the use of nonquantitative limits. According to a 2015 survey on access to care conducted by the National Alliance on Mental Illness (NAMI), respondents reported that they were twice as likely to be denied MH/SUD services based on medical necessity than medical services (NAMI 2015). NAMI has suggested this pattern of denials signals an impermissible disparity in the application of nonquantitative limits, but such a pattern may be difficult to observe from the vantage point of a single plan enrollee, who might otherwise bring a suit. These potential barriers to litigation around nonquantitative limits support a case for a public compliance-monitoring and enforcement mechanism to address both the unresolved issues in litigation we discuss here and other controversies that the current environment may suppress from the court system.

Though we have focused on the substantive topics at issue in parity litigation, recent cases bear mentioning for three procedural developments that may (on the other hand) facilitate continuing litigation around the MHPAEA. First, 2013's *C. M. v. Fletcher Allen Health Care Inc.*, discussed above, shifted the burden of proof to the insurance industry to justify nonquantitative differences in MH/SUD and medical benefits, easing the initial burden for potential plaintiffs. Second, 2015's *New York State Psychiatric Association v. UnitedHealth Group* implied that a third-party administrator of plan benefits could be held liable for violations of federal parity. Third-party administrators (as compared to health insurers or self-insured companies) were not previously considered an appropriate entity to sue for violations of federal parity, though they wield considerable power when it comes to approving or denying MH/SUD benefits claims. Third, in the same 2015 case, it was decided that a physician association could gain legal standing to pursue claims for a breach of federal parity on behalf of its individual members (providers of MH/SUD services) and their patients. These procedural developments—shifting the burden of proof of parity; including a major market player in the class of defendants that can be sued for noncompliance; and permitting providers, who may be in the best position to see certain breaches of parity, to pursue claims—may improve the enforcement of federal parity in the jurisdictions where

these cases were decided, and these decisions may prove influential to other courts throughout the country.

Three important limitations in this study should be noted. First, inherent in any qualitative research design is the potential for bias in the thematic review of the data. Our methods relied on two investigators conducting an independent review of the cases and reaching a consensus resolution with coinvestigators of varied policy research and legal backgrounds to identify themes in a valid manner. Second, the parity compliance issues subject to private litigation are not representative of the totality of potential compliance issues, since private legal action is a unique mechanism through which consumers and advocates register complaints. The six themes we describe may only be a subset of relevant areas for monitoring compliance with parity laws. Other research has demonstrated parity compliance issues around financial requirements and visit limits in the new individual and small group Marketplace plans, which we did not identify as a theme here (Berry et al. 2015). Third, this study is based on legal actions that have resulted in judicial opinions reported to the Westlaw databases. Litigation around parity laws is dynamic, and judicial opinions will not always reflect all issues raised, including complaints settled out of court or that have yet to reach judicial review. Nonetheless, our methods enable us to highlight the issues under litigation that are driving the evolution of case law in this area. The offsetting strengths of this study include the nuance and depth of the data, which we were able to describe in some detail using an inductive method. This study, in an effort to inform parity policy, provides the first evidence of themes in the substantive issues subject to private legal action around parity laws.

Policy Implications

Consumers and advocates have continued to turn to the courts to argue for nondiscriminatory coverage for MH/SUDs following the enactment of state and federal parity laws. In this litigation, courts have been asked to resolve controversies over what parity requires and how to evaluate compliance with those requirements; controversies over which laws, state or federal, govern MH/SUD insurance coverage; and finally, controversies over which directives—those issued by policy makers, rule-making bodies, or compliance-monitoring authorities—constitute the true requirements of parity. Though resolution of these disputes on a case-by-case basis offers one way for individuals to secure their rights to MH/SUD treatment, certain themes in litigation may also benefit from attention from outside the court system. Specifically, those themes that correspond with gaps in

regulation, such as those pertaining to exclusions of coverage for certain therapies or provider credentialing, signal areas where regulators could act to facilitate a greater understanding of parity implementation. Such attention would bring special expertise to bear on the task of defining the requirements of parity and head off the potential for inconsistent resolutions in case-by-case decisions through the courts. Other themes in litigation, such as those pertaining to exclusions of coverage for residential treatment and medical necessity determinations, may not benefit from additional rule making in the current regulatory environment. However, these areas, which are regulated by the parity standard for nonquantitative limits, warrant increased attention in compliance monitoring and public enforcement. This could ease the burden on potential plaintiffs to gain knowledge of their insurers' practices in order to initiate legal claims, and it may usefully expose insurers to incentives for compliance that exceed those created by the limited remedies individual plaintiffs are able to pursue through the courts.[8]

There is a strong case for regulators and oversight agencies to attend to the major issues subject to private legal action as potential areas for facilitating and monitoring compliance with parity laws. However, it is important to recognize that the courts have always played a role in interpreting and enforcing laws and will likely continue to do so in this policy area. For example, the final two themes we identified in the litigation, conflicts between parity and other laws and between parity policy and regulations, concern issues that are commonly decided by the courts. These sources of controversy account for challenges in the implementation of parity laws that may not benefit significantly from regulators' additional attention.

Securing rights to nondiscriminatory insurance coverage of MH/SUDs will occur through a concurrent effort by public oversight authorities together with private legal action. On the public enforcement front, in March 2016 President Barack Obama established an interagency parity task force to better ensure compliance with parity and to determine areas that would benefit from further guidance (Obama 2016). This study offers a partial response to this task by identifying themes in private litigation that connect to areas of uncertainty and controversy in the implementation of parity laws. Future research is needed to assess the frequency with which the controversial benefit limits and medical management practices we identify here occur, and their impact on access to MH/SUD services.

8. Many state and federal insurance parity laws lack a private right of action. Private plaintiffs must instead raise parity-related claims in the courts under the Employee Retirement Income Security Act of 1974, which provides for limited legal remedies, such as "clarifying" one's rights and recovering benefits due.

The passage of the MHPAEA and its extension via the ACA expanded the reach of insurance parity considerably. Uncertainty introduced by debates ongoing at press time around the ACA's future may further complicate efforts to implement the MHPAEA. As policy evolves, it will be important to monitor proposed changes that would alter or dismantle insurance parity in all relevant insurance markets.

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