

The Failed Promise of Mental Health Parity in Virginia: A Missing Key in Mental Healthcare Access

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THE FAILED PROMISE OF MENTAL HEALTH PARITY IN VIRGINIA: A MISSING KEY IN MENTAL HEALTHCARE ACCESS

ZACHARY WOERNER*

ABSTRACT

For those who suffer from the most serious mental illnesses, access to mental healthcare is critically important, but often frustrated by a Byzantine insurance system. The goal of this Note is to sift through the various mental health insurance parity laws, both nationally and statewide, and determine where this system breaks down. The Note will argue that lack of enforcement of parity laws plays a critical role in much of the dysfunction in the marketplace.

Legislation in Virginia and elsewhere is not always deficient on its face. Instead, laws critically lack regulators willing or able to implement them. This creates insidious problems in the mental healthcare market. The first place to begin enforcement is at the state level, where insurance regulation primarily occurs.

The President's Commission on Combating Drug Addiction and the Opioid Crisis recently recognized the need for greater enforcement of parity laws at the federal level as well. Although this Commission is primarily concerned with substance use disorders, it recognizes the crucial role that the Department of Labor has in enforcing federal parity laws. The DOL currently lacks the tools it needs to enforce these laws. It is encouraging that the Commission's Final Report recognizes this. Federal recognition of the problem is crucial, and increased enforcement could generate positive results for access to care throughout the country.

* JD Candidate, William & Mary Law School, Class of 2019. The author would like to thank his friends and family for their support during this process. This Note is dedicated to Jake Woerner. Thanks also to Katie Rockwell, Jessica Fetzer, and the staff of the *William & Mary Business Law Review* for their help in developing this Note.

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INTRODUCTION

Of the forty-three million American adults with some form of mental illness, ten million sufferers' are afflicted with a serious mental illness (SMI).¹ Out of that ten million, 140,000 of the seriously mentally ill are homeless; 392,037 are imprisoned; and 755,360 are on probation or parole.² Meanwhile, 95,000 seriously mentally ill persons who need hospitalization cannot find beds, and 5,000 kill themselves annually.³ These numbers are staggering, but do not fully represent the suffering felt by the mentally ill, their families, and society.⁴ And yet, the solutions proposed to address these seemingly intractable problems are all too often reactive in nature—and insufficient to meet the daunting task of reform.⁵

In Virginia, the problem of access to mental healthcare is particularly acute.⁶ In the wake of the Virginia Tech shooting and

¹ DJ JAFFE, *INSANE CONSEQUENCES: HOW THE MENTAL HEALTH INDUSTRY FAILS THE MENTALLY ILL* 20 (2017).

² *Id.*

³ *Id.*

⁴ *See id.* at 68–76 (The symptoms that accompany SMIs include hallucinations, delusions, and hearing voices that can lead to violence. Oftentimes sufferers also face severe cognitive dysfunction, which can be accompanied by total withdrawal from society. SMIs are physical brain disorders, and many suffer from anosognosia, meaning that sufferers have no insight into their illness. In addition, those who have a family member with an SMI are two to three times more likely to develop depression.); Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 28, 35–45 (2012) [hereinafter *Tovino, All Illnesses Are (Not) Created Equal*] (“U.S. employers incur anywhere from \$20 billion to \$40 billion per year in lost productivity due to employees’ mental illness.”); Mental Health America, *Position Statement 15: Parity in Health Insurance* (Sept. 13, 2014), <http://www.mentalhealthamerica.net/positions/parity#edn16> [<https://perma.cc/NRC9-SY54>] (“[I]ndirect costs associated with mental illness and substance abuse disorders—excess turnover, lost productivity, absenteeism and disability—commonly meet or exceed the direct treatment costs, and have been estimated to be as high as \$105 billion annually.”).

⁵ *See* JAFFE, *supra* note 1, at 21 (detailing tragedies that have resulted from violent, untreated seriously mentally ill individuals, such as the Virginia Tech shooting).

⁶ *See* K. Burnell Evans, *State official: Without action, Virginia’s public mental hospitals will overflow by 2024*, RICHMOND TIMES-DISPATCH (Sept. 28, 2017), <http://www.richmond.com/news/virginia/government-politics/general-assembly/state-official-without-action-virginia-s-public-mental-hospitals-will/article924a8871-a68b-510e-ba6d-98ae9f466e08.html> [<https://perma.cc/K87T-WPQ6>] (describing

the tragedy involving Gus Deeds, Virginia saw two wake up calls that have led to legislative action and the commitment of more resources to the problem.⁷ Reforms came in the wake of Gus Deeds's suicide and attempted murder of his father, Virginia State Senator Creigh Deeds.⁸ On the afternoon of November 18, 2013, Senator Deeds was unable to find his son a hospital bed in the state of Virginia and Gus was prematurely released from an emergency custody order.⁹ Once released, Gus attacked his father and committed suicide.¹⁰ This tragedy highlights the problem of access to adequate mental healthcare for the mentally ill.¹¹ Nevertheless, responses have been reactive, with a focus on addressing the immediate problems that crises present, such as increasing hospital beds after Senator Deeds was unable to find one, rather than focusing on systematic defects that create such emergencies in the first place.¹² Such a narrow focus on putting out fires, rather than

the prediction of overflow of Virginia's state mental hospitals without commitment of resources, and the hesitancy of some law makers to divert funds to state institutions, rather than community-based services).

⁷ See JAFFE, *supra* note 1, at 21 (The Virginia Tech shooter, Seung-Hui Cho, suffered from untreated serious mental illness. He killed thirty-two and wounded seventeen in April 2007.); Editorial Board, *On campuses and around Virginia, we see early signs of awareness and security on mental health*, DAILY PRESS (Apr. 19, 2017), <http://www.dailypress.com/news/opinion/editorials/dp-edt-mental-health-campus-security-0420-20170419-story.html> ("There are indications that our commonwealth is serious about its commitment to improving resources around the state.").

⁸ See Travis Fain, *Mental health reforms, and funding requests, emerging from Deeds study group*, DAILY PRESS (Oct. 29, 2016, 8:53 PM), <http://www.dailypress.com/news/politics/dp-nws-mental-health-funding-20161026-story.html> [<https://perma.cc/4H4V-DZ3S>]; David Ress, *Signs of hope on mental health 10 years after Tech tragedy*, DAILY PRESS (Apr. 15, 2017, 6:50 PM), <http://www.dailypress.com/news/politics/dp-nws-va-tech-mental-20170415-story.html> ("I believe the political will is there [to reform and commit additional resources].").

⁹ Prue Salasky, *Report on Deeds attack details flaws in crisis response*, DAILY PRESS (Mar. 27, 2014, 8:11 PM), <http://www.dailypress.com/health/dp-nws-deeds-report-issued-20140327-story.html> [<https://perma.cc/JVD5-UV3G>].

¹⁰ *Id.*

¹¹ *See id.*

¹² ARADHANA BELA SOOD & ROBERT COHEN, THE VIRGINIA TECH MASSACRE: STRATEGIES AND CHALLENGES FOR IMPROVING MENTAL HEALTH POLICY ON CAMPUS AND BEYOND 221 (2015) ("The focus in mental health services continues to be on reactive approaches, such as crisis stabilization units, rather than on outpatient care delivery or on prevention and health promotion.").

looking to the larger causes of those fires, means that insidious problems such as access to care, shortage of providers, and lack of resources go unaddressed.¹³

This Note argues that the source of these problems is a lack of enforcement of mental health insurance parity laws on the state and federal level, and that more vigorous enforcement of parity laws could represent a first step in increasing access to psychiatrists and other mental health providers. This Note will focus on the effect of under-enforcement of parity laws on access to psychiatric care in Virginia and look to examples in other states to highlight the different approaches being taken in response to this problem.

Part I of this Note will begin by briefly describing the federal legislative backdrop to mental health parity, along with its limitations. The Note will proceed to analyze the shared enforcement responsibility of the states and federal government, with an emphasis on the crucial role that states can play. Part II will identify greater enforcement of parity legislation on both the state and federal level as a potential first step in solving the greater issue of access to mental healthcare across the nation. Part III will detail various state legislative parity schemes, with a focus on Virginia. The Note will conclude by examining a promising new approach to enforcement of substance abuse treatment laws in New Jersey that could represent a critical step in increasing access to mental healthcare across the country.

I. THE FEDERAL LEGISLATIVE BACKDROP

Parity laws operate on both the state and federal levels.¹⁴ Efforts at achieving federal mental health parity began with the Mental Health Parity Act of 1996 (MHPA).¹⁵ MHPA regulated insured

¹³ See *id.* at 221–22.

¹⁴ See Hefei Wen et al., *State Parity Laws and Access to Treatment for Substance Use Disorder in the United States*, 70 JAMA PSYCHIATRY 1355, 1356 (Oct. 23, 2013).

¹⁵ Mental Health Parity Act of 1996, Pub. L. No. 104-204, sec. 7, § 712, 110 Stat. 2874 (1996) (codified as amended at 29 U.S.C. § 1185a (2006)). For a detailed discussion of the development of federal mental health parity legislation, see Tovino, *All Illnesses Are (Not) Created Equal*, *supra* note 4, at 35–45.

and self-insured group health plans of non-small employers,¹⁶ requiring that the lifetime and annual spending limits that a plan specifies not be different for physical and mental health benefits.¹⁷ For example, if a plan does not impose an aggregate lifetime or annual limit on covered physical benefits it may not impose such a limit on offered mental health benefits.¹⁸ One shortcoming of this law is that its protections did not reach people with substance abuse disorders (SUDs).¹⁹ Neither did it require a group health plan to actually offer any mental health benefits.²⁰

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) built upon the MHPA.²¹ The MHPAEA, like the MHPA, applied to insured and self-insured group health plans of non-small employers.²² Thus it “did not apply to small group plans, individual plans, the Medicare Program, Medicaid non-managed care plans, or ... self-funded, non-federal government plans whose sponsor opted out of MHPAEA.”²³ Like the MHPA, it did not require that insurers offer or provide any mental health benefits, but only applied if the plan already offered mental health coverage.²⁴

Substantively, it mandated that financial requirements (such as deductibles, co-pays, co-insurance, and other out-of-pocket expenses) and treatment limitations (inpatient day and outpatient visit limitations) that group health plans imposed on mental health

¹⁶ See Tovino, *All Illnesses Are (Not) Created Equal*, *supra* note 4, at 36 (defining “non-small ... as those employers that employ an average of [fifty-one] or more employees.”).

¹⁷ *Id.* at 37.

¹⁸ *See id.*

¹⁹ *Id.*

²⁰ *Id.* at 36 (“In terms of its substantive provision, MHPA was neither a mandated offer nor a mandated benefit law; that is, nothing in MHPA required a covered group health plan to actually offer or provide any mental health benefits.”).

²¹ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, secs. 511–12, 122 Stat. 3765, 3881–93 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)) [hereinafter Wellstone & Domenici].

²² See Tovino, *All Illnesses Are (Not) Created Equal*, *supra* note 4, at 38.

²³ *Id.*

²⁴ *See id.* (explaining that MHPAEA was “neither a mandated offer nor a mandated benefit law”).

and SUD benefits be no more restrictive than those imposed on physical health benefits.²⁵ Although the law is spotty in terms of its reach, the MHPAEA represented a major stride forward toward parity on the federal level.²⁶ As of January 13, 2014, the Final Rules implementing the MHPAEA went into effect.²⁷

Most recently in 2010, the Patient Protection and Affordable Care Act (ACA) expanded many of the protections offered by the MHPA and MHPAEA.²⁸ The ACA increased the scope of parity: new ACA-created state insurance exchanges now were also subject to MHPA and MHPAEA provisions.²⁹ Additionally, the ACA mandates that plans on state-run exchanges offer mental health and addiction coverage at parity with physical illness coverage.³⁰ This mandate is a big step because it requires the offer of mental health and SUD benefits for specified plans including “the exchange-offered qualified health plan, the non-exchange individual health plan, the non-exchange small group health plan, the Medicaid benchmark plan, the benchmark-equivalent plan, and the Medicaid state plan.”³¹

The surface of these federal legislative advances suggests substantial progress toward actual parity.³² All told, the MHPAEA extended parity to 103 million people in large-employer plans, while the ACA, in extending the application of the MHPAEA, affected

²⁵ *Id.*

²⁶ See Richard G. Frank, *Realizing the Promise of Parity Legislation*, 74 JAMA PSYCHIATRY 117, 117 (2017).

²⁷ Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68, 240 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 53, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–47).

²⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, sec. 1302(b)(1), 124 Stat. 119, 163 (2010) (codified at 42 U.S.C. § 18022(b)(1) (Supp. V 2012)); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified at 42 U.S.C. § 1305). Collectively, these two laws are now referred to as the Affordable Care Act. See Tovino, *All Illnesses Are (Not) Created Equal*, *supra* note 4, at 40.

²⁹ Aubrey Chamberlain, Note, *Stop the Bleeding: A Call for Clarity to Achieve True Mental Health Parity*, 20 WIDENER L. REV. 253, 259 (2014).

³⁰ *Id.*

³¹ See Tovino, *All Illnesses Are (Not) Created Equal*, *supra* note 4, at 41 (explaining these protections do not reach grandfathered health plans that were in effect on March 23, 2010, the day the law was signed).

³² See Frank, *supra* note 26, at 117.

an additional 30 million in small group plans, 18 million in the individual market, and 23 million under Medicaid.³³ With the future of the ACA in jeopardy due to political efforts to unwind it, these temporary federal gains are fragile.³⁴

Despite this surface-level progress, enforcement of federal and state parity provisions remains a problem.³⁵ However, some signs of hope exist. The recently formed President's Commission on Combating Drug Addiction and the Opioid Crisis shows that parity enforcement, at least for substance abuse treatment, is now a top priority on the federal level.³⁶

A. The Burden of Enforcement: State and Federal Legislative Dreams Deferred

While federal parity laws govern the majority of insurance plans in the nation, states have their own parity laws and regulators as well.³⁷ Enforcement of the parity laws falls mostly on the

³³ See *id.* (“The combined reach of MHPAEA and the ACA has affected the health insurance coverage for more than 170 million people.”).

³⁴ See Pete Early, *Guess Who Voted In Favor Of Bill That Every Mental Health Group Claims Will Put Millions At Risk?*, PETEEARLY (Mar. 13, 2017), <http://www.peteeearly.com/2017/03/13/guess-who-voted-in-favor-of-bill-that-every-mental-health-group-claims-will-put-millions-at-risk/> [<https://perma.cc/Y9MB-T4QK>] (“The Republican’s repeal legislation as currently written will end Obama-care’s Medicaid expansion, which covers 1.2 million Americans with serious mental illness and substance abuse problems, as well as [] scrap baseline coverage requirements.”).

³⁵ See Frank, *supra* note 26, at 118 (“[T]he federal government must ensure that a fabric of enforcement is in place [including] alignment of federal and state agencies that monitor and enforce the requirements of MHPAEA.”).

³⁶ See *infra* text accompanying notes 185–86.

³⁷ Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL’Y 455, 459–60 (2012) [hereinafter Tovino, *Reforming State Parity Law*] (citing 15 U.S.C. § 1012(a) (2010) “The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”) (“The regulation of insurance, including health insurance, traditionally has been a state responsibility.”); see also PATRICK J. KENNEDY & STEPHEN FRIED, A COMMON STRUGGLE 254, 360 (2015) (noting that “state laws often influence patient experiences much more than national mandates” and that parity is basically a state and local issue). But see Tovino, *Reforming State Parity Law*, *supra*, at 459 n.23 (citing 15 U.S.C. § 1012(b) (2010)) (reserving the right of Congress to pass certain federal legislation, provided that it relates to the business of insurance); 29 U.S.C. § 1144(a)

shoulders of the states.³⁸ States have taken divergent approaches to passing parity legislation of their own.³⁹ The twenty-three states with parity laws vary widely in composition and the degree to which they are enforced.⁴⁰ Even despite the legislative progress in many statehouses across the country, fundamental problems remain.⁴¹ These problems include weak or nonexistent parity laws and under-enforcement of parity laws generally.⁴² This combination of weak laws and under-enforcement has rippling effects through the mental healthcare market.⁴³

While state and federal regulators have an easier time ensuring parity of co-payments and deductibles, enforcement of the parity requirements for the actual delivery of medical services is lacking.⁴⁴ New York is one of the few states that now enforces parity.⁴⁵ In 2011, the Attorney General (AG) of New York's Health Hotline began noticing a pattern of denial of claims by insurers involving mental health addiction treatments.⁴⁶ After an AG investigation, it was discovered that some New York insurers denied

(explaining ERISA preempts state insurance laws that relate to employee benefit plans if the state law is not saved by ERISA's "savings clause").

³⁸ See Tovino, *Reforming State Parity Law*, *supra* note 37, at 486–87; see generally KENNEDY & FRIED, *supra* note 37, at 254 (noting that “state laws often influences patient experiences much more than national mandates” and that parity is basically a state and local issue).

³⁹ See Tovino, *Reforming State Parity Law*, *supra* note 37, at 487 (“many states have mental health parity laws that are contrary to or less stringent than federal law, especially MHPAEA and ACA.”).

⁴⁰ Michael Ollove, *Despite Laws, Mental Health Still Getting Short Shrift*, STATELINE (May 7, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/07/despite-laws-mental-health-still-getting-short-shrift> [<https://perma.cc/2NQ9-VH9J>]; see also Tovino, *Reforming State Parity Law*, *supra* note 37, at 461–79 (comparing the divergent parity laws in Vermont, Maryland, Nevada, and Idaho, which offer differing levels of protection).

⁴¹ See Tovino, *Reforming State Parity Law*, *supra* note 37, at 490–501.

⁴² See *id.* at 461–79, 487; Ollove, *supra* note 40.

⁴³ See, e.g., John Shemo et al., *Psychiatric Society of Virginia: District Branch Report* (Mar. 12–13, 2016), <http://www.psva.org/wp-content/uploads/2016/spring/district-branch-report.html> [<https://perma.cc/U6BU-97L3>] (explaining the lack of parity enforcement leads to “more and more psychiatrists [quitting] insurance panels, saving the insurance companies even more as patients are not able to find any ‘network providers’ and the companies reimburse the patient even less than they reimburse the network provider for using a ‘non-network provider.’”).

⁴⁴ Ollove, *supra* note 40.

⁴⁵ *Id.*

⁴⁶ *Id.*

nearly half of claims for behavioral health treatment.⁴⁷ Additionally, there were exclusions for certain types of treatment like eating disorders and a “fail first” policy before gaining approval to enter a residential facility.⁴⁸ In response, the New York AG reached settlements with five insurance plans for violating state parity laws.⁴⁹

In March 2015, the New York AG reached a \$900,000 settlement with Beacon Health Options, who was found to deny behavioral health claims twice as often as other medical or surgical claims, and four times as often for addiction recovery services.⁵⁰ The settlement also required that Beacon Health (formerly ValueOptions) overhaul its claim review process and cooperate with an ongoing appeal process for members who had been denied claims.⁵¹ In addition to the fine imposed, the settlement required Beacon Health to remove visit limitations for almost all behavioral health services, provide detailed rationale for denial of claims to allow for member appeals, reimburse coverage of treatment for diagnoses listed in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), and file regular compliance reports with the New York AG.⁵² The New York AG reached settlements with four other health plans found to be in noncompliance with parity laws.⁵³ As a result, “45 percent of previously rejected mental health and substance abuse claims [were] overturned on appeal.”⁵⁴ Successful enforcement efforts like this show that vigorous enforcement could yield similar benefits on the state and federal levels.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Press Release, AG Eric Schneiderman, A.G. Schneiderman Announces Settlement with ValueOptions to End Wrongful Denial of Mental Health and Substance Abuse Treatment Services (Mar. 5, 2015), <https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-valueoptions-end-wrongful-denial-mental-health> [<https://perma.cc/4RG8-W5ML>].

⁵¹ *Id.*

⁵² The settlement included many other provisions to ensure Beacon’s compliance with New York parity laws: it required that Beacon maintain an accurate online provider directory, conduct full and fair reviews of services that require preauthorization (e.g., inpatient SUD treatment), remove the “fail-first” standard previously applied for entry into residential services, and begin integrating medical and behavioral health claims. *Id.*

⁵³ Ollove, *supra* note 40.

⁵⁴ *Id.*

Patterns of discrimination are likely not confined to New York—they only came to light because of the Attorney General’s enforcement effort.⁵⁵ In the words of Patrick Kennedy, “it’s only logical that there are similar practices [of discrimination] in other states ... [insurance companies] can’t just be picking on New Yorkers.”⁵⁶ Emily Feinstein of CASAColumbia similarly opined, “I haven’t seen a lot of evidence of states enforcing parity.”⁵⁷

Even when the laws on the books are adequate, their under-enforcement leads to perverse outcomes that can be seen empirically.⁵⁸ In New York, where an aggressively enforced parity law was in place, 11 percent (1.8 million people) of the population suffered from a substance abuse disorder, but only 11 percent of those individuals (198,000 people) received any treatment.⁵⁹ In comparison, 70 percent of those with hypertension and diabetes received treatment.⁶⁰ This astonishing figure speaks clearly to the lack of access to care. Similarly, in a 2015 survey conducted by the National Alliance for Mental Illness, nearly one third of respondents in need of mental healthcare were denied care, over twice the rate of denial

⁵⁵ *See id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ Sarah Goodell, *Health Policy Brief: Enforcing Mental Health Parity*, HEALTH AFFAIRS (Nov. 9, 2015), <https://www.healthaffairs.org/doi/10.1377/hpb20151109.624272/full> [<https://perma.cc/7V9C-FJ9K>] (“Perhaps resulting from this patchwork [of regulatory authorities entrusted with enforcement including DOL, HHS, and other state insurance commissioners], enforcement on the state and federal levels has been minimal, with a few exceptions.”); *see also* Jenny Gold, *Congress tried to fix mental health care in 2008*, VOX (Aug. 3, 2015, 7:00 AM), <https://www.vox.com/2015/8/3/9069643/mental-health-parity-lawsuits> [<https://perma.cc/Q7SB-9PQN>] (according to Henry Harbin, Maryland’s former mental health director, “insurers are taking advantage of the minimal oversight.” With little oversight, insurers “micromanage care down to almost nothing.” Past hesitation to “step on the toes” of insurers could partly be explained by the Obama administration’s fear of angering insurers who were instrumental in helping the administration pass the Affordable Care Act).

⁵⁹ ATTORNEY GENERAL OF THE STATE OF NEW YORK, *IN RE VALUEOPTIONS, INC.*, ASSURANCE NO. 14-176, ASSURANCE OF DISCONTINUANCE UNDER EXECUTIVE LAW SECTION 63, SUBDIVISION 15 AT 3 (2015), <https://ag.ny.gov/pdfs/ValueOptionsAOD-FullyExecuted.pdf> [<https://perma.cc/874N-Z5WA>] [hereinafter *IN RE VALUEOPTIONS, INC.*].

⁶⁰ *Id.*

for general medical care.⁶¹ There is a clear link between under-enforcement of parity laws and lack of access to care.⁶²

The greater problem of access is likely also a result of lack of mental health resources.⁶³ In 2014, Paul Appelbaum, former Director of the American Psychiatric Association (APA) lamented the lack of resources dedicated to mental healthcare, particularly on the part of the federal government.⁶⁴

Those who wait on the federal government to jumpstart a “joint federal-state commitment ... to fund[] the infrastructure of a care system” will likely be waiting a long time.⁶⁵ Asking for more resources, in a more comprehensive way, is a contingent solution based on the dubious hope that the political will to commit more resources will suddenly appear.⁶⁶ Political will seems to be in short supply these days, particularly since the federal government

⁶¹ National Alliance on Mental Illness, *A LONG ROAD AHEAD: ACHIEVING TRUE PARITY IN MENTAL HEALTH AND SUBSTANCE USE CARE 4* (2015), <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf> [<https://perma.cc/PQ9L-97HH>] (comparing survey results from 2720 people in need of mental healthcare with an analysis of 84 health plans in 15 states, focusing on the results of the 1225 respondents with private insurance who are the subject of the final parity rule of July 1, 2014).

⁶² See Jonathan Purtle et al., *An audience research study to disseminate evidence about comprehensive state mental health parity legislation to US State policymakers: protocol*, 12 *IMPLEMENTATION SCI.* 1, 2 (2017), <https://implementationscience.biomedcentral.com/track/pdf/10.1186/s13012-017-0613-9> [<https://perma.cc/P2B6-9M7P>] (finding that insurer’s noncompliance with parity laws contributes to restricted access to services for “19 [percent] of the US population with a mental illness”); Goodell, *supra* note 58, at 4–5.

⁶³ See Paul S. Appelbaum, *How to Rebuild America’s Mental Health System, in 5 Big Steps*, *GUARDIAN* (May 29, 2014, 8:08 PM), <https://www.theguardian.com/commentisfree/2014/may/29/-sp-fix-america-mental-health-system-ideas> [<https://perma.cc/35EY-AT4Y>].

⁶⁴ “Today, paying for mental health care is nobody’s responsibility. Insurers pay as little as possible, often denying claims on flimsy grounds. States have cut more than \$4 [billion] from their mental health budgets in the last six years. The federal government directly contributes only a tiny amount to supporting mental health treatment beyond the coverage it provides through Medicare and Medicaid.” *Id.*

⁶⁵ *Id.*

⁶⁶ The plea for more federal money is not only contingent, but potentially also misguided: “Before investing more, we should ensure that a greater percentage of the existing mega mental health budget goes to serving the most seriously ill.” JAFFE, *supra* note 1, at 54–55.

already spends \$147 billion annually to fund mental health.⁶⁷ As demonstrated by the Substance Abuse and Mental Health Service Administration's (SAMHSA) Budget for Fiscal Year 2018, additional resources do not seem to be forthcoming; compared to its 2017 Fiscal Year Budget, SAMHSA's 2018 budget faced cuts of nearly \$400 million.⁶⁸

Nor is a lack of legislation the fundamental problem.⁶⁹ On paper, the laws are often adequate to put state and federal governments in the position to demand parity.⁷⁰ The problem is realization of this ideal, and mechanisms to ensure that what is written is carried out.⁷¹ The enforcement of state and federal parity laws needs to begin at the state level.⁷² Rather than dump more resources on the nonfunctioning system, governments need to recognize how to work smarter with less.⁷³ States need to start holding "insurers' feet to [the] fire to make certain they live up [to] their obligations under the Mental Health Parity Act."⁷⁴ Holding insurers accountable through enforcement of the law, particularly at the state level where insurance regulation primarily occurs, is a potential first step in addressing the broader issue of restricted access to care.⁷⁵

II. THE ELUSIVE SEARCH FOR ACCESS: ESTABLISHING A FUNCTIONAL MENTAL HEALTHCARE MARKET

Resources and access are closely related.⁷⁶ Lack of resources, or inefficient allocation of resources, exacerbates barriers to access.⁷⁷

⁶⁷ See *id.* at 21.

⁶⁸ Dept. of Health & Human Servs., *HHS FY 2018 Budget in Brief—SAMHSA* (last updated May 23, 2017), <https://www.hhs.gov/about/budget/fy2018/budget-in-brief/samhsa/index.html> [<https://perma.cc/WHT6-3QJ3>] (detailing a \$374 million decrease in discretionary budget authority for 2018).

⁶⁹ See Tovino, *Reforming State Parity Law*, *supra* note 37, at 461–79; Frank, *supra* note 26, at 117–18.

⁷⁰ See Tovino, *Reforming State Parity Law*, *supra* note 37, at 461–82.

⁷¹ See Goodell, *supra* note 58, at 4–5.

⁷² See Tovino, *Reforming State Parity Law*, *supra* note 37 and accompanying text.

⁷³ See *supra* note 66 and accompanying text.

⁷⁴ See Appelbaum, *supra* note 63.

⁷⁵ See *id.*

⁷⁶ See *id.* But see JAFFE, *supra* note 1, at 54–55.

⁷⁷ See Appelbaum, *supra* note 63.

Commitment of resources toward enforcement of parity laws could be a relatively cheap first step to laying the foundation of a functional mental healthcare market.⁷⁸ Particularly since mental health resources are under attack at the federal level, and because \$147 billion is already being spent by the federal government, shifting the focus to enforcement where it has the potential to be most effective—at the local level—is a logical first step.⁷⁹

As discussed above, insurance companies frequently deny or undercompensate claims relating to mental health procedures, which has a twofold effect.⁸⁰ First, it discourages people from seeking out care, for fear of not being reimbursed.⁸¹ Those who do receive care may be denied coverage for medically necessary treatment and saddled with unconscionably high bills that their insurance theoretically should cover.⁸²

Second, mental healthcare providers are less likely to accept private insurance, Medicaid, or Medicare, for fear that they will not be reimbursed for the procedure.⁸³ A study published in JAMA

⁷⁸ See Gold, *supra* note 58. Such implementation could be cheap from an administrative perspective, but potentially expensive to insurers, who are resistant to such regulatory scrutiny, and who are large political stakeholders.

⁷⁹ See *supra* note 52 and accompanying text.

⁸⁰ See PATRICK J. KENNEDY & STEPHEN FRIED, A COMMON STRUGGLE 254, 360 (2015); John Shemo et al., *Psychiatric Society of Virginia District Branch Report to the Area V Council Meeting*, PSYCHIATRIC SOCIETY OF VIRGINIA DISTRICT BRANCH REPORT (Spring 2016), <http://www.psva.org/wp-content/uploads/2016/spring/district-branch-report.html> [<https://perma.cc/U6BU-97L3>]; Tovino, *Reforming State Parity Law*, *supra* note 37, at 455, 459–60 (2012); Michelle Ollove, *Despite Laws, Mental Health Still Getting Short Shrift*, STATELINE (May 7, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/07/despite-laws-mental-health-still-getting-short-shrift> [<https://perma.cc/2NQ9-VH9J>]; *supra* notes 37–43 and accompanying text.

⁸¹ DEPT. OF HEALTH & HUMAN SERVS., *Mental Health: A Report of the Surgeon General* 457 (1999) (“Financial obstacles discourage people from seeking treatment and from staying in treatment. Repeated surveys have shown that concerns about the cost of care are among the foremost reasons why people do not seek care.”).

⁸² See *Parity: What’s Next?*, THE KENNEDY FORUM (Nov. 7, 2017), <https://thekennedyforum.org/parity-whats-next/>; *infra* notes 168–69 and accompanying text (detailing a New Jersey woman’s story of taking out a mortgage to fund inpatient treatment for her two sons, whose medical bills amounted to over \$300,000 combined).

⁸³ Tara F. Bishop et al., *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*, 71 JAMA PSYCHIATRY 176, 179 (2013), <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1785174?version=meter%20at%2015&module=meter-Links&pgtype=article&contentId>

Psychiatry found that only 55 percent of psychiatrists accepted private insurance.⁸⁴ This was small compared to the 89 percent acceptance rate of other medical specialties.⁸⁵ Rather than fight with insurance companies to get paid, which is time consuming and may jeopardize the viability of their practice, many psychiatrists opt out of the health insurance market entirely and only accept patients who will pay out-of-pocket.⁸⁶ For the mental healthcare patient or consumer, the problem of access is acutely felt.⁸⁷ It is very difficult for consumers to find a living psychiatrist within the insurer's network, who is accepting new patients.⁸⁸ In a study of three major cities, after one round of phone calls, investigators were able to reach 119 out of 360 psychiatrists (33 percent), and after a second round of calling, were able to successfully make appointments with ninety-three psychiatrists (26 percent).⁸⁹ A similar study in Washington, D.C. found that only fourteen percent of psychiatrists listed in-network were available to schedule new outpatient appointments, the other eighty-six percent either unreachable or not taking new patients.⁹⁰ This is a nonfunctioning market.⁹¹

By enforcing parity, some stability would be injected into a dysfunctional market. In Virginia, for instance, the effect of non-enforcement of parity laws is a flight from Virginia by providers.⁹²

=&mediaId=&referrer=https://www.google.com/&priority=true&action=click&contentCollection=meter-links-click [https://perma.cc/4533-ETQY].

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *See id.*

⁸⁷ *See id.*

⁸⁸ *See, e.g.,* Monica Malowney et al., *Availability of Outpatient Care from Psychiatrists: A Simulated-Patient Study in Three U.S. Cities*, 66 PSYCHIATRIC SERVS. 94, 94–96 (2015), <http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201400051> [https://perma.cc/89RX-NWGB] (conducting a phone survey in Boston, Chicago, and Houston of all Blue Cross Blue Shield providers in the cities to determine the extent of availability of in-network providers).

⁸⁹ *Id.*

⁹⁰ *Majority of Psychiatrists Listed in DC Health Insurance Exchange Network Not Available For New Patient Appointments*, AM. PSYCHIATRIC ASS'N (May 16, 2016), <https://www.psychiatry.org/newsroom/news-releases/majority-of-psychiatrists-listed-in-dc-health-insurance-exchange-network-not-available-for-new-patient-appointments> [https://perma.cc/LEJ8-BVRM].

⁹¹ *See id.*

⁹² John Shemo, *American Psychiatric Association Assembly Meeting*, PSYCHIATRIC SOC'Y OF VA NEWS, Winter 2015, at 19, http://www.psva.org/wp-content/uploads/2015/12/PSV_VA_News_Winter2015_web1.pdf [https://perma.cc

Knowing that they will not be reimbursed by insurance companies for the services they render, psychiatrists often either refuse to accept private insurance or flee from the state altogether.⁹³ When insurance companies fail to reimburse psychiatric procedures at the same rate as other medical procedures, the effect is to depress wages for psychiatrists.⁹⁴ Enforcing parity provisions would address the brain-drain problem in states like Virginia.⁹⁵ It would also work toward stabilizing a market for care by getting providers on board and creating incentives for them to operate in the market, rather than outside of it.⁹⁶

Insurers play a key role in this conversation.⁹⁷ Many likely ignore the laws on the books and get away with it.⁹⁸ Anecdotal evidence of noncompliance is often all that is available, however, because insurers refuse to release information about the rates at which they reimburse, reasoning that the information is proprietary.⁹⁹

A recent survey of forty-two million patients from 2013 to 2015 confirms that there are significant disparities between mental

/WGW9-AKAB] (detailing the flight of nearly eighty percent of psychiatric residency trainees from Virginia).

⁹³ *Id.* (“This [flight from Virginia] is in part due to the extremely low insurance reimbursement schedules for psychiatrists in Virginia.”).

⁹⁴ Jennifer Nelson, *Talk is cheap: How insurance changed the face of psychiatry*, INSURE (Feb. 6, 2013) (asserting that “doctors can’t afford to go into psychiatry because of [low] insurance reimbursement [rates] [I]t is the lowest paying field for doctors and, with the cost of additional medical school for specialization, it isn’t worth it.” In addition, “mental health professionals have arguably the worst reimbursements in health care, and many are leaving the field or working outside of the health care insurance system.”).

⁹⁵ See Shemo, *supra* note 92, at 19.

⁹⁶ See Goodell, *supra* note 58, at 5.

⁹⁷ See Gold, *supra* note 58.

⁹⁸ *Id.* (“[D]emonstrating that an insurer has violated parity rules requires a detailed analysis of a plan’s mental health and medical benefits [While] the law requires that insurers disclose that information, critics say they often do not comply.” Indeed, “virtually no insurers will release documents.”); *Despite Federal Law, Some Insurance Exchange Plans Offer Unequal Coverage for Mental Health*, JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (Mar. 2, 2015), <https://www.jhsph.edu/news/news-releases/2015/despite-federal-law-some-insurance-exchange-plans-offer-unequal-coverage-for-mental-health.html> [https://perma.cc/K3TV-VMLS] (detailing how one quarter of plans sold on Obamacare exchanges in two states appeared to violate federal parity laws).

⁹⁹ See Gold, *supra* note 58.

and physical healthcare reimbursement rates.¹⁰⁰ This study demonstrated that both primary and specialty care providers received higher reimbursement rates than did behavioral health providers for comparable services.¹⁰¹ In addition, the study found that mental health patients used out-of-network providers substantially more often than did medical/surgical care patients.¹⁰² In 2015, the proportion of behavioral healthcare provided out-of-network was 3.6 to 5.8 times higher than was the proportion of medical/surgical care.¹⁰³ The two findings are likely closely related: lower reimbursement rates offered to mental health providers likely lead to providers not opting in to a health plan's network, thus creating difficulty for patients looking for scarce in-network mental health providers.¹⁰⁴

Demonstrating the abstract concepts described above is an exchange between Anthem Virginia and Dr. John Shemo, a Virginia provider and former director of the Psychiatric Society of Virginia.¹⁰⁵ In the letters between Dr. Shemo and the Anthem representative, Dr. Shemo complains about Anthem's discriminatory practice of denying reimbursement for certain procedure

¹⁰⁰ STEPHEN P. MELEK ET AL., ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: ANALYZING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT RATES 1 (2017), <http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf> [<https://perma.cc/W5U7-VVLZ>].

¹⁰¹ Across the country, when compared to behavioral health providers, primary care providers received a 20.7 to 22 percent higher average reimbursement rate, while specialists received a 17.1 to 19.1 percent higher rate. *Id.* at 2. In Virginia from 2013 to 2015, primary care reimbursement rates were on average 39.53 percent higher than behavioral reimbursement rates, while average specialist rates were 32.26 percent higher. *See id.* at apps. J–L.

¹⁰² The study found that “[o]ut-of-network utilization for behavioral care nearly doubled in the inpatient setting, increasing from 9.6 [percent] to 16.7 [percent], and more than doubled in the outpatient facility setting, increasing from 15.6 [percent] to 31.6 [percent] between 2013 and 2015.” Out-of-network behavioral healthcare utilization is much higher when compared to medical/surgical out-of-network patient utilization, which consistently hovered between 3.4 and 4 percent for inpatient facilities and between 5.3 and 5.6 percent for outpatient facilities. *Id.* at 3–4.

¹⁰³ *Id.* at 3.

¹⁰⁴ *Id.* at 2–3.

¹⁰⁵ Letter from John Shemo, Med. Director, Psychiatric Alliance of the Blue Ridge, to Anthony L. Pelonero, Med. Director, Behavioral Health Care, Anthem Blue Cross & Blue Shield of Va. (July 15, 2013), http://www.psva.org/wp-content/uploads/2013/11/Letter_Shemo_Request_15Jul13.pdf [<https://perma.cc/X9GT-9MQB>] [hereinafter Shemo Letter].

codes.¹⁰⁶ Anthem justified its denial of Dr. Shemo's reimbursement request by stating that his "diagnosis and procedure codes [were] not 'compatible.'"¹⁰⁷ Such an exchange demonstrates Dr. Shemo's frustration in dealing with Anthem. More importantly, it demonstrates the difficulties of running a business dependent upon such reimbursements.¹⁰⁸ For psychiatrists like Dr. Shemo, conducting an hour worth of treatment for less than \$50 is not justifiable.¹⁰⁹ As the Milliman study demonstrates, disparate insurance company reimbursement practices likely contribute to psychiatrists' decision not to opt in to health plans.¹¹⁰

The insurance company's response is instructive as well.¹¹¹ In response, Dr. Anthony Pelonero of Anthem justifies the insurance company's denial:

Anthem's reimbursement rates for psychiatrists and other physicians are market driven and reflect a myriad of factors, including the fact that psychiatrists, on average, have a lower cost structure than most other physicians. Parity requires the use of comparable processes, strategies, evidentiary standards, and other factors, for mental health benefits and medical/surgical benefits, and it requires that these factors are applied in a comparably stringent manner. It does not require that the reimbursement rates for evaluation and management services performed by psychiatrists be the same.¹¹²

¹⁰⁶ *See id.*

¹⁰⁷ *See id.* (alteration in original) ("Anthem sees fit to 'allow' only \$49.96 for this hour of service, \$19.96 from Anthem and \$30.00 from the patient. They are reimbursing the 99213 code but are denying the accompanying 90836 code in its entirety, saying that the diagnosis and procedure codes are not 'compatible.' The diagnosis codes used are directly from the DSM-IV and similar codes are in the DSM-5. Thus, they are by definition psychiatric diagnosis codes used with psychiatric procedure codes.").

¹⁰⁸ *See id.*; *see also* Shemo, *supra* note 92 (explaining that Anthem Blue Cross/Blue Shield, the largest insurer in Virginia, "reimburses for procedure codes 99213/90836 and 99214/90836 at less than half of the Medicare reimbursement rates").

¹⁰⁹ Shemo Letter, *supra* note 105.

¹¹⁰ *See* MELEK ET AL., *supra* note 100, at 2–3.

¹¹¹ Letter from Anthony L. Pelonero, Med. Director, Behavioral Health Care, Anthem Blue Cross & Blue Shield of Va., to John Shemo, Med. Director, Psychiatric Alliance of the Blue Ridge (Sept. 12, 2013), http://www.psva.org/wp-content/uploads/2013/11/Letter_Pelonero_Response_15Jul13_12Sep13.pdf [<https://perma.cc/62E3-YVR9>] [hereinafter Pelonero Letter].

¹¹² *Id.*

Regardless of the legal validity of this position, one thing is clear: the provider will not be reimbursed at actual parity, and the insurance company is not operating outside of the law.¹¹³ Anthem's justification is an economic one.¹¹⁴ A psychiatrist's cost structure is not the same as that of most ordinary physicians, and so the insurance company is not required to reimburse at the same rate.¹¹⁵ An investigation into the state legislative scheme will yield an answer on whether this is correct or not.¹¹⁶ Nevertheless, the limiting effect of such an approach on access to treatment is clear.¹¹⁷ This trend can be seen on the micro-level as well. When one of Virginia's largest insurers frequently reimburses providers at a fraction of the rate of other comparable procedures, this disincentivizes providers from accepting that insurance, which creates downward pressure on the wages of psychiatrists, and so disincentivizes psychiatrists from operating in the market.¹¹⁸

Even assuming the costs of enforcing parity would be out of step with the services rendered, the insurance company clearly misses the broader individual, familial, and societal impacts of its actions.¹¹⁹ There are extreme negative externalities in the fallout from the lack of access to adequate mental health services.¹²⁰ Ultimately, by deferring necessary treatment, insurers may also be shooting themselves in the foot.¹²¹ Some estimates say that the societal costs that result from inadequate treatment exceed \$100 billion per year.¹²² These costs are likely not the foremost

¹¹³ *See id.*

¹¹⁴ *See id.*

¹¹⁵ *See id.*

¹¹⁶ *See infra* Part III; *see also* Gold, *supra* note 58 (insurers more often require preauthorization for psychiatric doctor visits, have "fail first" policies for access to inpatient care, and require determinations of "medical necessity" before patients are covered for appropriate levels of care).

¹¹⁷ *See, e.g.*, Bishop et al., *supra* note 83, at 176–80.

¹¹⁸ *See* MELEK ET AL., *supra* note 100, at 2–3; Shemo, *supra* note 92; Pelonero Letter, *supra* note 111; Shemo Letter, *supra* note 105; *see also supra* notes 108–12 and accompanying text.

¹¹⁹ *See* Tovino, *All Illnesses Are (Not) Created Equal*, *supra* note 4.

¹²⁰ *Id.*

¹²¹ *See, e.g.*, Gold, *supra* note 58 ("The irony in all this is that [the insurer] fights tooth and nail to dole out care for my son. But had they allowed him upfront to get the care he needed, he might not have ended up back in the hospital, which they had to pay for.") (alteration in original).

¹²² *Id.*

concern of insurance companies, who have their shareholders and bottom line to worry about.¹²³ Some studies suggest, however, that by not adequately treating mental health, the cost that insurance companies pay for physical treatments goes up as well.¹²⁴ This phenomenon is known as the offset effect.¹²⁵

Insurance companies justify not offering mental health and SUD benefits at parity by claiming that doing so will raise costs for insurers.¹²⁶ However, many studies refute this claim.¹²⁷ One such study compared patients diagnosed with depression to those without it and found that untreated, depressed patients have higher medical costs on average, “associated with a twofold increase in use of health services.”¹²⁸ The greater utilization of medical services by depressed patients was found to be more costly than the costs associated with treating the depression itself.¹²⁹

In a similar 2009 study, 14,902 Medicare beneficiaries with either diabetes, congestive heart failure, or both were split into three groups: those diagnosed with depression, those not officially diagnosed but who screened positive, and those who were not depressed.¹³⁰ Those diagnosed with depression incurred \$22,960 in total costs over one year on average, with mental healthcare costs accounting for less than 2 percent of total health costs.¹³¹ By comparison, those without depression had costs of \$11,956 per year, and those with possible depression had costs of \$14,365.¹³² Higher Medicare co-payments for outpatient mental healthcare at the time (50 percent co-pay for outpatient mental versus 20 percent for outpatient physical healthcare at the time of the study) were likely an obstacle for depressed patients that stopped them from

¹²³ See Tovino, *All Illnesses Are (Not) Created Equal*, *supra* note 4, at 9–13.

¹²⁴ See *id.* at 10–32.

¹²⁵ See *id.* at 29 n.195.

¹²⁶ See *id.* at 4.

¹²⁷ See *id.* at 15–27.

¹²⁸ See *id.* at 15 (citing Greg E. Simon et al., *Health Care Costs of Primary Care Patients with Recognized Depression*, 52 ARCHIVES GEN. PSYCHIATRY 850, 850–54 (1995)).

¹²⁹ See *id.* at 16.

¹³⁰ See *id.* at 18–20 (citing Jürgen Unützer et al., *Healthcare Costs Associated with Depression in Medically Ill Fee-for-Service Medicare Participants*, 57 J. AM. GERIATRIC SOC. 506 (2009)).

¹³¹ *Id.* at 19.

¹³² *Id.*

seeking outpatient mental health treatment entirely.¹³³ The study concluded that increased utilization of evidence-based depression care could generate long-term cost savings.¹³⁴ Instead of increased costs, these studies show that shifting resources to needed mental health treatment may actually generate cost savings for insurers when taking account of total healthcare costs.¹³⁵

Another study found that each dollar invested in full-continuum and partial-continuum addiction care generated returns that were 9.7 and 23.3 times their baseline investments, respectively.¹³⁶ The study concluded that both types of “addiction care can generate positive and significant net benefits to society.”¹³⁷ Increased mental health and substance abuse treatment, when medically necessary, can generate net economic benefits contrary to the claims of insurers; policy makers should take notice.¹³⁸

III. VIRGINIA’S LEGISLATIVE SCHEME IN THE NATIONAL CONTEXT

A. *Virginia’s Lack of Enforcement Weakens an Otherwise Strong Law*

Virginia, when compared to other states, has a typical state mental health parity law.¹³⁹ The law first specifies that group and individual health insurance coverage “shall provide mental health and substance use disorder benefits.”¹⁴⁰ The Virginia law goes beyond the MHPAEA, insofar as it mandates that a specified subclass of insurers offer mental health and substance abuse benefits.¹⁴¹ This is referred to as a “mandated benefit” law.¹⁴²

¹³³ *Id.*

¹³⁴ *Id.* at 19–20.

¹³⁵ *See id.*

¹³⁶ *Id.* at 22 (full-continuum care cost averaged \$2,530 and generated economic benefits of \$20,639, while partial-continuum average cost was \$1,138 with \$12,130 average economic benefits).

¹³⁷ *Id.*

¹³⁸ *See generally* Purtle et al., *supra* note 62.

¹³⁹ VA. CODE ANN. § 38.2-3412.1 (West 2017).

¹⁴⁰ *Id.* § 38.2-3412.1(B).

¹⁴¹ *Id.*; *see* Wellstone & Domenici, *supra* note 21.

¹⁴² *See* Tovino, *Reforming State Parity Law*, *supra* note 37, at 463–64 (“Mandated benefit laws require all health insurance plans to include the mandated

The types of insurers that fall into the subclass that must offer mental health benefits include “group and individual health insurance coverage,” excepting grandfathered plans in the small group market, which have explicit limitations on the extent of coverage for inpatient and outpatient services available.¹⁴³ Virginia law similarly requires that state employee health plans offer coverage for a “biologically based mental illness.”¹⁴⁴

Curiously, section 38.2-3412.1 contains no such reference to “biologically based mental illness,” but defines “mental health services,” as those benefits “for mental health conditions as defined under the terms of the health benefit plan ... [with any condition defined therein] to be consistent with generally recognized independent standards of current medical practice.”¹⁴⁵ This raises the question: what is the scope of a “mental health condition”? In practice, the scope is whatever the insurance plan chooses to define it as, so long as the definition is consistent with current standards of medical practice.¹⁴⁶ Contrast this definition with Vermont’s parity law, which defines “mental health condition” as inclusive of “all mental illnesses listed in the mental disorders section of the

benefit ... regardless of whether a particular insured requires or believes she will require the benefit.”).

¹⁴³ § 38.2-3412.1(B)–(D) (limiting inpatient care in grandfathered small group plans to twenty days for adults per year and twenty-five days for children, allowing for conversion of ten days of inpatient care to fifteen days of partial hospitalization benefit; and providing that such plans provide a minimum of twenty outpatient treatment visits for adults and children (excluding medication management visits), providing minimum levels of co-insurance coverage of 50 percent to outpatient visits beyond the first five visits, and providing that if all covered expenses for an outpatient visit or substance abuse treatment apply toward any deductible required by policy or contract, such visit shall not count toward the outpatient benefit maximum).

¹⁴⁴ VA. CODE ANN. § 2.2-2818(B)(17) (West 2017) (defining “biologically based mental illness” as “any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person’s functioning,” specifically including “schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction”).

¹⁴⁵ VA. CODE ANN. § 38.2-3412.1(A) (West 2017) (alteration in original) (emphasis added).

¹⁴⁶ *See id.*

current edition of the [International Classification of Disease].”¹⁴⁷ The Vermont law thus requires insurance plans to cover the full range of neurological, psychiatric, substance abuse, developmental, and intellectual disorders.¹⁴⁸ The Virginia law is nowhere near as comprehensive in scope in comparison.¹⁴⁹ This could potentially give Virginia insurers an escape hatch through which they could avoid covering certain legitimate mental health conditions by not including them in the terms of the health benefit plan.¹⁵⁰

Nevertheless, the Virginia law specifically tethers itself to the MHPAEA, requiring that the benefits provided for mental health and substance use disorders be in parity with the medical and surgical benefits contained in a plan’s coverage, in accordance with the MHPAEA.¹⁵¹ By adopting the financial requirements and treatment limitations of the MHPAEA for all but grandfathered small group plans, and mandating that plans offer mental health benefits, the Virginia parity law apparently goes a step beyond the federal law.¹⁵² In theory, the tools are present for compliance with the parity laws, and yet reality tells a different story entirely.¹⁵³ While it is possible that insurers manage to get out of covering mental health conditions by simply not including certain conditions in the terms of their plans, it is unclear to what extent this potential loophole is exploited.¹⁵⁴ In Virginia, the law itself is not lacking.¹⁵⁵ Instead, lack of enforcement is why the benefits of Virginia’s parity law are not realized.¹⁵⁶

¹⁴⁷ See Tovino, *Reforming State Parity Law*, *supra* note 37, at 464–65.

¹⁴⁸ See *id.*

¹⁴⁹ See *id.*

¹⁵⁰ See MELEK ET AL., *supra* note 100, at 2–4; Shemo Letter, *supra* note 105; see also *supra* notes 102–05.

¹⁵¹ VA. CODE ANN. § 38.2-3412.1(B) (West 2017); see Wellstone & Domenici, *supra* note 21.

¹⁵² See § 38.2-3412.1(B).

¹⁵³ See MELEK ET AL., *supra* note 100, at 2–3; Shemo, *supra* note 92; Pelonero Letter, *supra* note 111; Shemo Letter, *supra* note 105; see also *supra* notes 108–12 and accompanying text.

¹⁵⁴ See MELEK ET AL., *supra* note 100, at 2–3; Shemo, *supra* note 92; Pelonero Letter, *supra* note 111; Shemo Letter, *supra* note 105; see also *supra* notes 108–12 and accompanying text.

¹⁵⁵ See § 38.2-3412.1.

¹⁵⁶ See *id.*

B. Recent Developments: Executive Recognition that Enforcement of Parity Laws for Substance Use Disorders Needs to Be on the State and Federal Levels

In response to an ever-worsening opioid crisis across New Jersey, former Governor Chris Christie called for the passage of a bill restricting the ability of insurance companies to deny coverage for inpatient and outpatient addiction treatment.¹⁵⁷ The bill, signed into law on February 15, 2017, mandates that a “hospital service corporation contract that provides ... benefits ... shall provide unlimited benefits for inpatient and outpatient treatment of substance use disorder at in-network facilities.”¹⁵⁸ Moreover, those diagnosed with a SUD have treatment coverage “for the first 180 days per plan year ... when determined medically necessary by the covered person’s physician, psychologist or psychiatrist without imposition of any prior authorization or other prospective utilization management requirements.”¹⁵⁹ Importantly, “the first 28 days of an inpatient stay during each plan year shall be provided without any retrospective review or concurrent review of medical necessity ...” by the insurer or hospital providing care, and treatment for SUDs must be covered by carriers “to the same extent as for any other medical condition covered under the contract,” that is without increased co-pays, deductibles, or co-insurance.¹⁶⁰ In a promising signal of its intent, the law also emboldens the New Jersey Attorney General’s Office to oversee administration of the law and authorizes punishment for any violations resulting from “fraud, abuse, waste, and mistreatment of covered persons.”¹⁶¹

¹⁵⁷ See Sarah Frostenson, *New Jersey Just Passed One of the Most Aggressive Laws to Combat the Opioid Epidemic*, VOX (Feb. 15, 2017, 4:30 PM) (noting that prior to passage of the law, Governor Christie called for such legislation in his State of the State address on January 10, 2017), <https://www.vox.com/policy-and-politics/2017/2/15/14506434/republicans-democrats-opioid-abuse-bipartisan> [<https://perma.cc/B9GM-ACS3>].

¹⁵⁸ See 2017 N.J. Sess. Law Serv. 1 (West) (codified as amended at N.J. STAT. ANN. § 17:48-6nn(a) (2017)).

¹⁵⁹ *Id.* § 17:48-6nn(b) (no “prior authorization or other prospective utilization management requirements.”); *id.* § 17:48-6nn(c) (“[no] pre-payment of medical expenses during this 180 day in excess of applicable co-payment, deductible, or co-insurance under the contract”).

¹⁶⁰ *Id.* §§ 17:48-6nn(e)–(f) (“medical necessity shall be as determined by the covered person’s physician”); *id.* § 17:48-6nn(k).

¹⁶¹ *Id.* § 17:48-6nn(n).

By putting such explicit pressure on insurance companies, this represents the strongest legislative reform in the nation addressing access to substance abuse treatment.¹⁶² Since the New Jersey law is specifically targeted at substance abuse treatment, the legislative and administrative fixes in New Jersey presumably do not extend to other forms of mental healthcare treatment.¹⁶³ Nonetheless, New Jersey's bold posture serves as an example of what is possible for enforcement.¹⁶⁴ The legislative and regulatory posture is being backed up by a concerted effort to sign contracts with existing acute-care general hospitals in New Jersey and build new private inpatient hospitals, adding nearly 900 psychiatric and drug treatment beds throughout New Jersey by 2019.¹⁶⁵ After all, legislative and regulatory fixes are great, but if there are not enough providers or beds to offer services, than yelling about parity will only go so far, because inadequate resources will ultimately limit access due to scarcity.¹⁶⁶

Former Governor Christie has channeled his efforts in New Jersey to the national level in his capacity as the Chairman of the President's Commission on Combating Drug Addiction and the Opioid Crisis.¹⁶⁷ During his remarks on November 1, 2017, before the Commission, then-Governor Christie responded to a New Jersey woman, Roxanne Schwartz, who gave heartbreaking testimony about her need to pay over \$300,000 out-of-pocket to get her two sons inpatient treatment for their addictions.¹⁶⁸ Even

¹⁶² PARTNERSHIP FOR A DRUG-FREE NEW JERSEY, *Governor Christie Signs America's Strongest Drug Addiction and Treatment Reform Legislation* (Feb. 15, 2017), <http://www.drugreenj.org/news/governor-christie-signs-americas-strongest-drug-addiction-treatment-reform-legislation/> [https://perma.cc/A4AR-M9JU].

¹⁶³ See Frostenson, *supra* note 157 and accompanying text.

¹⁶⁴ See *id.*

¹⁶⁵ Susan K. Livio, *Christie Says Promise on Addiction, Mental Health Treatment Coming True in 2019*, NJ (Nov. 18, 2017), http://www.nj.com/politics/index.ssf/2017/11/nj_will_add_900_new_addiction_and_mental_health_tr.html [https://perma.cc/2LXA-UPX5].

¹⁶⁶ See *id.*

¹⁶⁷ See The President's Commission on Combating Drug Addiction and the Opioid Crisis, *Final Report*, at 5, 7 (Nov. 2, 2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_11-2-2017.pdf [https://perma.cc/8RL9-Z96R] [hereinafter The President's Commission].

¹⁶⁸ The White House, Meeting of the President's Commission on Combating Drug Addiction and Opioid Crisis [5th and final meeting] (Nov. 1, 2017), <https://www.whitehouse.gov/featured-videos/video/2017/11/01/meeting-presidents>

after Roxanne filed seven appeals to her insurance company, the insurers refused to reimburse her.¹⁶⁹

While the newly passed New Jersey law would have prevented insurance companies from behaving in such a way, Christie noted that New Jersey “is only able to regulate 30 [percent] of the health insurance plans in our state” with the other seventy percent of plans regulated by the U.S. Department of Labor (DOL).¹⁷⁰ While DOL is responsible for regulating the majority of health insurance plans in the country, it lacks the enforcement authority necessary to hold insurers accountable.¹⁷¹

C. The President’s Commission Final Report and its Recommendations for Action Going Forward

The Commission’s Recommendations recognize the importance of parity in resolving the problem of access to care.¹⁷² One of the most important Recommendations, number 35, recommends that “Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations.”¹⁷³ While the MHPAEA has been on the books since 2008, and the final rules implementing it were published in November 2013, the would-be enforcer, the DOL, has lacked the ability to enforce the law.¹⁷⁴ That there has been formal recognition of the shocking lack of teeth in implementing the MHPAEA, is a positive sign for reform at the federal level.¹⁷⁵

Recommendation 34 also recognizes the concern of John Shemo discussed in Part II, *supra*, about the disparate levels of reimbursement for SUD treatment providers.¹⁷⁶ Indeed, because

-commission-combating-drug-addiction-and-opioid [https://perma.cc/U2EQ-3XAR] [hereinafter President’s Commission Video].

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ See The President’s Commission, *supra* note 167, at 9.

¹⁷² See *id.* at 6.

¹⁷³ *Id.* at 72.

¹⁷⁴ See *id.* at 9.

¹⁷⁵ See *id.* at 71.

¹⁷⁶ See *id.* at 70 (“Lack of sufficient reimbursement impedes the ability of professionals and practices to implement high-quality and consistent care, including but not limited to the use of EHRs, the implementation of evidence-based practices, and the routine use of quality metrics.”).

of the disparate rates of reimbursement, “many practitioners no longer take insurance, diminishing access to care even when there appears to be sufficient capacity.”¹⁷⁷ To remedy this, the Commission recommends that HHS “review and modify [the] rate-setting” process “to better cover the true costs of providing SUD treatment for both inpatient psychiatric facility and outpatient provider rates.”¹⁷⁸ This again is a sound proposal, given the downward pressure on access that disparate reimbursement practices have.¹⁷⁹

Another relevant portion of the final report, Recommendation 36, recognizes the common pitfalls that bedevil enforcement of the parity laws on the state and federal levels.¹⁸⁰ While monitoring parity compliance for co-pays and deductibles may be a relatively simple task, other “non-quantitative treatment limitations” (NQTLs) are not so simple to comply with, and as a result often are not adhered to.¹⁸¹ NQTLs include “stringent prior authorization and medical necessity requirements.”¹⁸² The Commission recommends that HHS review the clinical guidelines to support NQTL parity requirements, and that federal and state regulators use a standard tool requiring “health plans to document and disclose their compliance”¹⁸³ Again, this is a powerful suggestion. Although it is one that may be more difficult to implement given the need for more rigorous regulatory oversight, which remains elusive.¹⁸⁴

These suggested regulatory and legislative interventions are apparently directed specifically at substance abuse treatment, but likely include the broader array of mental health treatments as well.¹⁸⁵ This is heartening because it represents the first time that parity enforcement is a top priority at the highest level of government, that is with President Trump.¹⁸⁶ If the breakdown of state versus federally administered health plans across the nation is like that of New Jersey, that is with 70 percent of plans subject to

¹⁷⁷ *Id.*

¹⁷⁸ *Id.* at 15.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* at 72.

¹⁸¹ *Id.*

¹⁸² *Id.* at 72.

¹⁸³ *Id.*

¹⁸⁴ See Goodell, *supra* note 58 and accompanying text.

¹⁸⁵ See The President’s Commission, *supra* note 167, at 71.

¹⁸⁶ See *Parity: What’s Next?*, *supra* note 82, at 3.

federal parity laws, then increased federal attention to enforcement is critical to access and could potentially cut administrative costs.¹⁸⁷

Potentially, however, there may be a problem of give-and-take. Given that the opioid crisis is currently at the forefront of policymakers' minds, it is possible that other mental health patients may be neglected.¹⁸⁸ As seen in the case of New Jersey, the rigorous new law passed last year is specifically tailored to address the needs of those who require substance abuse treatment, but does not extend similar protections to those who suffer from serious mental illnesses and who may face the same barriers to treatment.¹⁸⁹

It remains to be seen whether the laudable ends of the New Jersey law are realized, and whether there is a positive spillover to other mentally ill patients.¹⁹⁰ When resources are tight however, it could be that there are winners and losers from a shift in resources.¹⁹¹ This is not to diminish Governor Christie's efforts. The former Governor did well to increase access for SUD patients both legislatively and by physically increasing access to additional hospital beds.¹⁹² This is the kind of activity that needs to happen across the country.¹⁹³ Giving DOL the authority to monitor compliance with the parity laws, and thus giving teeth to the MHPAEA, would be a critical step in increasing access to mental healthcare across the country.¹⁹⁴

CONCLUSION

For too long those with serious mental illness have been denied access to crucial care.¹⁹⁵ The state of mental healthcare is one where finding a provider is a small miracle, and denial of coverage is commonplace.¹⁹⁶ This creates a barrier to access that

¹⁸⁷ See President's Commission Video, *supra* note 168.

¹⁸⁸ See Frostenson, *supra* note 157 and accompanying text.

¹⁸⁹ See *id.*

¹⁹⁰ See *id.*

¹⁹¹ See JAFFE, *supra* note 1, at 55.

¹⁹² See PARTNERSHIP FOR A DRUG-FREE NEW JERSEY, *supra* note 162, at 1.

¹⁹³ See Frostenson, *supra* note 157, at 5.

¹⁹⁴ See The President's Commission, *supra* note 167, at 71.

¹⁹⁵ See JAFFE, *supra* note 1, at 54 (providing statistics on lack of access to medical care and the tragic effects).

¹⁹⁶ See National Alliance on Mental Illness, *supra* note 61, at 2 and accompanying text.

can seem insurmountable. Often the perpetrators of these denials, insurance companies, are legally required to cover mental health patients at parity with other procedures, but fail to do so.¹⁹⁷ A reassessment of the entire mental healthcare system is necessary to cure these longstanding deficiencies.¹⁹⁸

One of the foremost obstacles to access is under-enforcement of parity laws.¹⁹⁹ Particularly at the state level, where much of insurance regulation occurs, enforcement of parity laws could represent a first step toward stabilizing a nonfunctioning market.²⁰⁰ The aggressive enforcement actions of the New York AG show the potential of parity laws and should be emulated in other states.²⁰¹ In a sector where resources are tight, doing more with less is necessary.²⁰²

Ramped up enforcement activity is also needed on the federal level. In some states, like New Jersey, the DOL is responsible for regulating the majority of the state's insurance plans.²⁰³ It is promising that the federal government is starting to recognize the importance of giving federal regulators the tools necessary to enforce the law.²⁰⁴ The President's Commission on Combating Drug Addiction and the Opioid Crisis holds promise of reform for substance use disorders, but it remains to be seen how exactly this plays out for mental health generally.²⁰⁵

In the end, this is a human rights issue that has been ignored for too long at the pain and expense of too many. Providers currently have the perverse incentive to operate outside of the dysfunctional insurance market.²⁰⁶ A shakeup is needed of the current regime, and a focus on working to more effectively utilize the laws that exist would be a good first step toward increasing access.

¹⁹⁷ See Bishop et al., *supra* note 83, at 2.

¹⁹⁸ See Appelbaum, *supra* note 63, at 3.

¹⁹⁹ See President's Commission Video, *supra* note 168.

²⁰⁰ See Tovino, *Reforming State Parity Law*, *supra* note 37, at 456.

²⁰¹ See *IN RE VALUEOPTIONS, INC.*, *supra* note 59, ¶ 14.

²⁰² See JAFFE, *supra* note 1, at 54–55.

²⁰³ See The President's Commission, *supra* note 167, at 72.

²⁰⁴ *Id.* at 9.

²⁰⁵ See *id.* at 12–18 (providing a summary of the Commission's 56 recommendations).

²⁰⁶ See Bishop et al., *supra* note 83, at 176.