

THE YALE LAW JOURNAL

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Divide and Conquer? Lessons on Cooperative Federalism from a Decade of Mental-Health Parity Enforcement

ABSTRACT. Ten years after the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), parity between mental health/substance use disorders and medical/surgical benefits remains elusive. This Note describes the statute's cooperative federalist framework and analyzes enforcement data and settlement documents demonstrating the role of states in prospective enforcement. In comparing the MHPAEA to other cooperative statutes, it concludes that MHPAEA compliance could be improved by expanding private rights of action, promoting stakeholder collaboration, utilizing conditional spending, and allowing for waivers. The Note also renews calls for consumer education, clarifying regulations, and proactive enforcement by federal agencies and states.

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INTRODUCTION

John¹ was a bright, hardworking student who earned admission to an Ivy League college in early 2010.² Over the course of his first year, he developed a severe mental illness and, after he attempted suicide, was forced to withdraw. Twice in the next year, he was hospitalized for acute psychotic episodes. With his insurance covering multiple therapy sessions each week, John was diagnosed with bipolar disorder and began to recover.

His progress halted, however, when his insurance company retracted his benefits, claiming that his frequent visits were no longer medically necessary.³ Though his father argued that the company had illegally applied a more stringent medical-necessity determination for mental-health benefits than they used for medical or surgical benefits, the company remained resolute. Because John's family could not afford the unreimbursed cost of frequent treatments, his condition deteriorated until he was forced to withdraw from his dream school.

For decades, consumers like John have found that medical insurance coverage for mental-health conditions remains systematically inferior to that for non-mental-health conditions.⁴ In 1997, 86% of health insurance plans imposed stricter limits for inpatient mental-health care than for inpatient medical or surgical care, and 96% dictated stricter limits for outpatient mental-health care than for equivalent medical or surgical care.⁵ Similarly, among health-maintenance organizations (HMOs), only 24% covered inpatient alcohol detoxification treatment without restrictions, as opposed to 59% for inpatient medical/surgical treatments.⁶

To address glaring disparities in insurance coverage, the first state mental-health-parity laws—which require equality in insurance coverage for mental

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1. “John” is a pseudonym adopted to avoid disclosure of his mental illness.
 2. See Memorandum of Law in Support of Plaintiff's Motion for Preliminary Injunction at 11-13, *N.Y. State Psychiatric Ass'n v. UnitedHealth Grp.*, 980 F. Supp. 2d 527 (S.D.N.Y. 2013) (No. 13 Civ. 1599 CM.).
 3. *Id.* at 12-13.
 4. The Diagnostic and Statistical Manual of Mental Disorders classifies substance-use disorders as “primary mental health disorders.” See Sean M. Robinson & Bryon Adinoff, *The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations*, 6 BEHAV. SCI. 18, 18 (2016).
 5. Haneefa T. Saleem, *New Law Moves Insurance Plans Closer to Total Mental Health Parity*, U.S. BUREAU LAB. STAT. 5 (Sept. 22, 2003), <https://www.bls.gov/opub/mlr/cwc/new-law-moves-insurance-plans-closer-to-total-mental-health-parity.pdf> [<https://perma.cc/PLN3-B7YF>].
 6. *Id.* at 3.

health and medical or surgical care—were passed in the 1970s.⁷ Early conceptions of parity varied widely among states, and advocates lobbied aggressively for comprehensive federal legislation.⁸ Years of lobbying efforts and state experimentation yielded the first federal law in 1996: the Mental Health Parity Act (MHPA).⁹ The MHPA required that insurers covering mental-health benefits offer the same annual and lifetime spending limitations for mental health as they did for medical care.¹⁰ Although the MHPA made valuable strides in achieving mental-health parity, it fell short in various respects—namely, it allowed employers to opt out of mental-health coverage altogether, neglected substance-use disorders (SUDs), and in some instances exempted employers from the new parity requirements altogether.¹¹

The Mental Health Parity and Addiction Equity Act (MHPAEA), passed in 2008 and taking effect in early 2010, marked a sea change in mental-health parity and the federal regulation of health insurance more generally.¹² The MHPAEA mandated that insurance plans treat mental-health (MH) benefits the same as medical/surgical (M/S) benefits, and it extended these comprehensive parity requirements to SUDs.¹³ Specifically, it required that MH/SUD benefits be granted no less freely than the “predominant” rules that governed “substantially all” M/S benefits.¹⁴ It also stipulated that MH/SUD benefits should not have separate cost-sharing requirements or treatment limitations from M/S benefits.¹⁵ The MHPAEA enjoyed broad bipartisan support and its legislative history is replete with sentimental moments, as congressional lead-

7. See Susan L. Ettner, Jessica M. Harwood, Amber Thalmayer, Michael K. Ong, Haiyong Xu, Michael J. Bresolin, Kenneth B. Wells, Chi-Hong Tseng & Francisca Azocar, *The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Specialty Behavioral Health Utilization and Expenditures Among “Carve-Out” Enrollees*, 50 J. HEALTH ECON. 131, 131 (2016).

8. See *id.* at 132.

9. Mental Health Parity Act of 1996 (MHPA), Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a and 42 U.S.C. § 300gg-5 (2018)).

10. See Suann Kessler, *Mental Health Parity: The Patient Protection and Affordable Care Act and the Parity Definition Implications*, 6 HASTINGS SCI. & TECH L.J. 145, 154 (2014).

11. See, e.g., 29 U.S.C. § 1185a(c)(1) (2018) (exempting group health plans offered by “small employers”); Kessler, *supra* note 10, at 154.

12. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, 122 Stat. 3881 (codified at 26 U.S.C. § 9812, 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26 (2018)).

13. See, e.g., MHPAEA § 512(a)(1).

14. *Id.*

15. *Id.*

ers shared personal experiences with mental illness.¹⁶ Its passage was hailed not just as effective policy, but also expressive of the indignity caused by treating mental conditions as what Congressman Patrick Kennedy called “second-class illnesses.”¹⁷

The MHPAEA also reflected a school of thought that state and federal governments should cooperate to administer programs rather than occupy “separate spheres.”¹⁸ Known as cooperative federalism, this theory formed the basis of many statutes passed after the 1960s, including many involving health insurance.¹⁹

Despite the promise of the MHPAEA and the cooperative federalist principles along which it was designed, stories like John’s remain common nearly a decade later. Insurance coverage for MH/SUD benefits continues to be more expensive and more limited than for comparable M/S benefits.²⁰ Those seeking MH/SUD treatment are between five and ten times more likely to utilize out-of-network care, thereby greatly expanding their out-of-pocket costs.²¹ For in-network services, significant disparities remain in reimbursement rates, with primary-care reimbursements 23.8% higher than behavioral reimbursements.²² Disparities in reimbursement rates have increased steadily since the passage of the MHPAEA.²³

16. See Colleen L. Barry, Haiden A. Huskamp & Howard H. Goldman, *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 415-17 (2010).

17. *Id.* at 415.

18. Keith E. Whittington, *Dismantling the Modern State? The Changing Structural Foundations of Federalism*, 25 HASTINGS CONST. L.Q. 483, 485 (1998).

19. Medicaid, authorized in 1965 under Title XIX of the Social Security Act, is the “nation’s largest cooperative federalism program.” Cooperative federalism later found expression in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (ACA). Outside of health-insurance regulation, the theory is also reflected in the Public Utility Regulatory Policies Act of 1978 and the Telecommunications Act of 1996. The McCarran-Ferguson Act of 1945 established the foundation for such statutes, declaring that states may regulate the “business of insurance” where Congress has been silent. Pub. L. No. 79-15, 59 Stat. 33 (codified at 15 U.S.C. §§ 1011-1015 (2018)).

20. Steve Melek, Stoddard Davenport & T.J. Gray, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, MILLIMAN (Nov. 19, 2019), http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf [<https://perma.cc/P9FB-JDPM>].

21. *Id.* at 6.

22. *Id.*

23. See *id.*

Unequal access to MH/SUD benefits is ever more pressing as our society's mental-health crisis continues to grow. One study based on World Health Organization survey data estimates that nearly fifty percent of Americans will be diagnosed with a mental illness at some point in their lifetime, even without accounting for underdiagnosis due to disparities in access to care, insurance coverage, and stigma.²⁴ In any given year, one in five adult Americans experiences mental illness,²⁵ and for one in twenty-five the mental illness is seriously debilitating.²⁶ Over twenty million people aged twelve or older have a substance-use disorder.²⁷

Although the MHPAEA regulates the insurance coverage of hundreds of millions of individuals, scholarly analysis of the law has typically focused on a single aspect of enforcement or the protections afforded for a single mental illness.²⁸ Kathleen Noonan and Stephen Boraske characterize the MHPAEA as an exemplar of "concurrent enforcement" (another term for cooperative federalism) in which the federal and state governments share responsibility for enforcing national policy.²⁹ Aviv Shamash notes the interaction between the Employee Retirement Income Security Act of 1974 (ERISA) and certain portions of state parity laws.³⁰ Many critics have called for more robust enforcement of

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24. See Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of Mental Disorders in the World Health Organization's World Mental Health Survey Initiative*, 6 *WORLD PSYCHIATRY* 168, 170-72 (2007).
 25. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., HHS PUB. NO. SMA 16-4984, KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2015 NATIONAL SURVEY ON DRUG USE AND HEALTH 28 (2016).
 26. Seriously debilitating illnesses include bipolar disorder, schizophrenia, and major depression. *Id.*
 27. *Id.* at 2.
 28. See Kathleen G. Noonan & Stephen J. Boraske, *Enforcing Mental Health Parity Through the Affordable Care Act's Essential Health Benefit Mandate*, 24 *ANNALS HEALTH L.* 252, 256 (2015); see also Paul Garcia, *The Problem with Parity: An Analysis of the Confusion Surrounding the California Mental Health Parity Act*, 87 *S. CAL. L. REV. POSTSCRIPT* 38 (2014) (discussing California parity law, particularly through anorexia cases); Carol Gyurina, *Beyond Parity: Medicaid Policy and Improving Access to Effective Substance Use Disorder Treatment*, 58 *MED. CARE* 99 (2020) (focusing on opioid-use disorder and other SUDs); Joni Roach, *Discrimination and Mental Illness: Codified in Federal Law and Continued by Agency Interpretation*, 2016 *MICH. ST. L. REV.* 269, 269 (focusing heavily on the anorexia parity case law).
 29. See Noonan & Boraske, *supra* note 28, at 252, 256.
 30. See Aviv Shamash, *A Piecemeal, Step-by-Step Approach Toward Mental Health Parity*, 7 *J. HEALTH & BIOMEDICAL L.* 273, 292-93, 302-09 (2011). For a discussion of how ERISA interferes with federal health-insurance regulation, see generally Abbe R. Gluck, Allison K. Hoffman & Peter D. Jacobson, *ERISA: A Bipartisan Problem for the ACA and the AHCA*,

the MHPAEA at both the state and federal levels, but there has been scant scholarly attention to the Act's convoluted enforcement structure or its lackluster outcomes.³¹ Furthermore, scholars have not comprehensively considered landmark state parity settlements, such as those in Massachusetts and New York.³² Finally, though authors have described the cooperative-federalist theory underpinning Medicaid and the ACA at length, there has been little effort to situate the MHPAEA within the continuum of cooperative health-insurance statutes.³³

To address this gap and render suggestions for future comprehensive federal health-insurance legislation, this Note explores the ways in which developing federal preemption doctrine and a fragmented health-insurance system have undermined the MHPAEA's potential. To do so, this Note presents detailed state and federal enforcement data from the first full decade under the

HEALTH AFF. BLOG (June 2, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170602.060391/full> [<https://perma.cc/BY96-Q2MF>].

31. See, e.g., Michael C. Barnes & Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 558-59 (2014); Benjamin D. Heller, *Revolutionizing the Mental Health Parity and Addiction Equity Act of 2008*, 47 SETON HALL L. REV. 569, 571-72 (2017); Sarah Goodell, *Enforcing Mental Health Parity*, HEALTH AFF. BLOG (Nov. 9, 2015), <https://www.healthaffairs.org/doi/10.1377/hpb20151109.624272> [<https://perma.cc/ES4N-5VSU>] (discussing enforcement through 2015). All sources describe the MHPAEA's enforcement structure in varying degrees of detail but do not address the theory of federalism that underwrites it.
32. See, e.g., Goodell, *supra* note 31 (acknowledging the New York settlement with Excellus and some other aspects of ongoing enforcement efforts but providing only limited information on the MHPAEA's enforcement structure); *State's Insurer Agreements Designed to Improve Patient Access to Care*, MENTAL HEALTH WKLY., Mar. 9, 2020, at 1 (acknowledging the Massachusetts settlement in brief).
33. See Sara Rosenbaum, *Can This Marriage Be Saved? Federalism and the Future of U.S. Health Policy Under the Affordable Care Act*, 15 MINN. J.L. SCI. & TECH. 167 (2014); see also Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1, 4 (2017) (arguing that the ACA "properly assumes control over money but also wrests more regulatory authority from states than necessary"); Charlton C. Copeland, *Beyond Separation in Federalism Enforcement: Medicaid Expansion, and the Norm of Engagement*, 15 U. PA. J. CONST. L. 91, 95 (2012) ("[T]he Medicaid Expansion provision directly implicated the states in the plan to ensure health care for all."); Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 470, 540 (2011) ("[S]tatutes like the ACA substantiate the central role that Congress long has asked the states to play in federal statutory implementation."); Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Health Care for?*, 70 STAN. L. REV. 1689, 1731 (2018) ("Medicaid has always been structured under the use-it-or-lose-it model of cooperative federalism, and the ACA continued that.").

MHPAEA. Throughout, we examine the MHPAEA and its attendant enforcement problems through the lens of cooperative federalism.

Part I of this Note explores the MHPAEA's structure and history as a primer to its unique brand of cooperative federalism. It first defines the law's structure and how it allocates enforcement responsibility among several federal agencies and states. It then discusses the theory underpinning this structure, including its payoffs and pitfalls for enforcement. We next describe the MHPAEA's enforcement history before and after the ACA and the 21st Century Cures Act (Cures Act)—both of which significantly affected the parity landscape.

Part II of this Note will delve into the MHPAEA's enforcement at both the federal and state levels. It focuses on case studies of two states that reached landmark parity settlements. Together, these case studies suggest that state enforcement has significant potential to increase compliance.

Finally, Part III considers possible reforms to the MHPAEA and discusses lessons for understanding cooperative federalist statutes more generally. It first identifies successful elements of other cooperative federalist statutes, such as enhanced public participation and private rights of action. It then recommends a set of reforms for the MHPAEA, including encouraging coordinated federal activity, expanding state enforcement, clarifying regulations and improving consumer education, and refocusing on outcomes.

I. THE EVOLUTION OF THE MHPAEA

Although the coverage requirements and enforcement structure of the MHPAEA are complex, the concept of parity, the MHPAEA's organizing principle, is simple: insurance plans should not impose more restrictive standards on the coverage of MH/SUD benefits than they do for M/S benefits.³⁴ To accomplish this goal, the MHPAEA targets both financial requirements known as “quantitative treatment limitations” (QTLs)—such as copayments and deductibles—and nonquantitative treatment limitations (NQTLs)—such as prior authorization requirements and limits on the frequency of treatment. Requirements for MH/SUD benefits may be “*no more restrictive than the predominant financial requirements applied to substantially all*” covered M/S benefits.³⁵ As will be discussed in Section I.C, this ambiguous statutory language constitut-

34. See Lindsey Vuolo, Robyn Oster & Ellen Weber, *Evaluating the Promise and Potential of the Parity Act on Its Tenth Anniversary*, HEALTH AFF. BLOG (Oct. 10, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181009.356245> [<https://perma.cc/6H8L-T8DK>].

35. MHPAEA § 512(a)(1) (emphasis added).

ing the key parity requirements frustrated enforcement efforts in the early years of the MHPAEA, and as a result, MHPAEA enforcement has since been fashioned around interpretive guidance and regulations issued by a variety of state and federal enforcement agencies.³⁶

The involvement of numerous state and federal agencies in MHPAEA enforcement has led to structural ambiguity—resulting from complex and overlapping enforcement jurisdictions—as well as textual ambiguity. Because the complex web of enforcement and interpretive authority has given rise to many enforcement challenges, this Section begins first by detailing the structural characteristics of the MHPAEA. It then describes the theory and history underlying the cooperative federalist approach adopted by lawmakers. Finally, it presents a history of efforts to clarify and implement the law in light of its cooperative foundation.

A. Structural Characteristics of the MHPAEA's Scheme

In light of the fragmentation of American health-insurance regulation across various federal statutes in the decades prior to the MHPAEA's enactment, the MHPAEA required the amendment of three separate federal laws that implicated a wide array of federal and state agencies (see *Table 1* below). To regulate plans offered by large employers, the Act amended both ERISA and the Internal Revenue Code to give the Department of Labor's (DOL) Employee Benefit Securities Administration (EBSA) and the Department of Treasury (Treasury) overlapping enforcement authority over parity requirements.³⁷ To regulate a variety of public plans and gap-fill state enforcement efforts, the Act amended the Public Health Service Act, thereby conferring primary oversight authority upon the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS).³⁸ All three federal agencies share joint interpretive authority over the MHPAEA's requirements in addition to their individual enforcement responsibilities.³⁹

36. See Goodell, *supra* note 31, at 4 (describing the monitoring of parity compliance as spread across a “patchwork of regulatory authorities”).

37. See MHPAEA § 2(a)(1), (c)(1).

38. See *id.* § 2(b).

39. See *Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008*, U.S. DEP'T LAB. (May 9, 2012), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/understanding-implementation-of-mhpaea.pdf> [<https://perma.cc/7L2C-CLSC>].

Although states have historically been primarily responsible for regulating insurance,⁴⁰ the MHPAEA emphasizes federal involvement in part because states cannot regulate a number of key insurance plans. Significantly, states are preempted by ERISA from regulating large employer-based group health plans, which cover over 135 million participants and beneficiaries.⁴¹ States are also preempted from regulating Medicare and Medicare Advantage plans, which cover an additional 60 million individuals.⁴² Finally, states cooperatively regulate Medicaid and Children’s Health Insurance Program (CHIP) plans—which cover approximately 70 million individuals at any given time—in conjunction with CMS, although states must do so in accordance with federal benchmarks.⁴³

This manifold preemption landscape tightly constrains state mental-health parity legislation. In 2016, only 74.4 million individuals out of a total of approximately 272 million insured individuals were enrolled in primarily state-regulated insurance.⁴⁴ Furthermore, a number of states opt not to enforce

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40. See Brendan S. Maher & Radha A. Pathak, *Enough About the Constitution: How States Can Regulate Health Insurance Under the ACA*, 31 YALE L. & POL’Y REV. 275, 278 (2013) (noting states’ “historic role in the regulation of insurance”).
41. U.S. DEP’T OF LABOR, PARITY PARTNERSHIPS: WORKING TOGETHER 5 (2020), <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf> [<https://perma.cc/Z7JK-CUYK>]; *id.* at 10 n.8 (“In general, ERISA section 514 provides that state laws are preempted to the extent that they relate to any ERISA-covered employee benefit plan . . .”).
42. See 42 U.S.C. § 1395w-26(b)(3) (2018); *Total Number of Medicare Beneficiaries*, KAISER FAM. FOUND. (2020), <https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries> [<https://perma.cc/5QUF-ELCS>]. The MHPAEA requirements do not extend to Medicare, making the program a significant gap in the mental-health parity landscape. See U.S. DEP’T OF HEALTH & HUMAN SERVS., CONSISTENCY OF LARGE EMPLOYER AND GROUP HEALTH PLAN BENEFITS WITH REQUIREMENTS OF THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, at 4 (Nov. 1, 2013), https://aspe.hhs.gov/system/files/pdf/117351/mhpaAct_o.pdf [<https://perma.cc/4CW6-R4MM>].
43. States can apply for Section 1115 Demonstration Waivers allowing for flexibility under federal Medicaid laws. Thirty-seven states have approved waivers related to behavioral health provisions as of January 26, 2021. See *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Jan. 26, 2021), <https://www.kff.org/Medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state> [<https://perma.cc/7FKZ-Q5ZB>].
44. See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-20-150, MENTAL HEALTH AND SUBSTANCE ABUSE: STATE AND FEDERAL OVERSIGHT OF COMPLIANCE WITH PARITY REQUIREMENTS VARIES 11 (Dec. 2019), <https://www.gao.gov/assets/710/703239.pdf> [<https://perma.cc/7JTK-R7L5>]; see also U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2017, 4 tbl.1 (Sept. 2018), <https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf> [<https://perma.cc/7FR2-7JGA>] (providing further statistics on enrolled populations).

MHPAEA requirements, leaving to CMS the need to assume issuer-level oversight authority.⁴⁵

Private citizens' roles in the MHPAEA's structure are similarly limited. While *in theory* complaints by private citizens can initiate federal enforcement actions under the MHPAEA, complaint volume has remained low—in part because neither state nor federal governments have expended much effort to educate citizens about their rights under the MHPAEA.⁴⁶ As a result, complaints tend to be limited to certain kinds of NQTLs rather than QTLs, which often require access to internal carrier information such as relative reimbursement rates.⁴⁷

45. For further details, see *infra* Section II.B.

46. See U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 44, at 42.

47. See Kelsey N. Berry, Haiden A. Huskamp, Howard H. Goldman, Lainie Rutkow & Colleen L. Barry, *Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity*, 42 J. HEALTH POL. POL'Y & L. 1065, 1078, 1093-95 (2017) (finding that only two of twenty-five cases sampled involved quantitative treatment limitations).

DIVIDE AND CONQUER?

TABLE 1.
JURISDICTIONS OF THE VARIOUS MHPAEA ENFORCEMENT ENTITIES

Enforcement Entity	Jurisdiction
DOL (Employee Benefits Security Administration)	Fully insured, private-employer-sponsored plans (large group, > 50 employees) ⁴⁸
	Self-funded, private-employer-sponsored plans (large group, > 50 employees) ⁴⁹
HHS (CMS)	Fully-insured, non-federal governmental plans (i.e., plans for employees of state and local governments) ⁵⁰
	Self-funded, non-federal governmental plans ⁵¹
	Individual and fully-insured group market issuers in states that opt not to enforce or fail to substantially enforce the MHPAEA ⁵²
	Medicaid Alternative Benefit (Benchmark) Plans, Medicaid managed care plans, and Children’s Health Insurance Program plans ⁵³

48. See U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 44, at 14.

49. *Id.*

50. *Id.*

51. *Id.*

52. Currently, CMS enforces the MHPAEA requirements in four states that have opted not to enforce the law: Missouri, Oklahoma, Texas, and Wyoming. See EMP. BENEFITS SEC. ADMIN, FY 2019 MHPAEA ENFORCEMENT 1, <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2019.pdf> [<https://perma.cc/2APB-M4QS>]. CMS has collaborative enforcement agreements with five states: Alabama, Florida, Louisiana, Montana, and Wisconsin. *Id.*

53. See generally Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18,389 (Mar. 30, 2016) (codified at 42 C.F.R. pts. 438, 440, 456, 457) (applying requirements in the Public Health Service Act to Medicaid managed-care organizations, Medicaid Alternative Benefit Plans, and Children’s Health Insurance Programs).

Department of Transportation	Overlapping authority with DOL (Employee Benefits Security Administration) ⁵⁴
	Under the MHPAEA, issuer-level oversight over individual and fully insured group markets ⁵⁵
Various State Entities (e.g., Departments of Insurance, Attorneys General)	Under state law, plan-level oversight of non-ERISA regulated plans ⁵⁶
	Medicaid Alternative Benefit (Benchmark) plans, Medicaid managed-care plans, and Children's Health Insurance Program plans ⁵⁷
Private Litigants	Private actions against fully insured and self-funded private-employer plans (large group, > 50 employees) ⁵⁸

The choice of this divided enforcement structure makes sense in light of cooperative federalism, a governmental theory which was popular at the time of the MHPA's and the MHPAEA's passages. The next section will define cooperative federalism and use the theory to analyze the structure of the MHPAEA.

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54. See generally Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68,239 (Nov. 13, 2013) (codified at Treas. Reg. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146-47) (identifying Treasury and DOL as the regulators to ensure that employer health benefit plans comply with the statute's parity requirements).
55. See 42 U.S.C. § 300gg-22(a)(1) (2018); U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 44, at 4.
56. States have wide latitude to regulate insurance plans when not preempted by federal law. See, e.g., MASS. GEN. LAWS ch. 175 § 47EE (2021) (requiring most insurance policies issued within the state to "provide coverage for abuse deterrent opioid drug products . . . on a basis not less favorable than non-abuse deterrent opioid drug products").
57. State Medicaid departments' enforcement jurisdiction over these Medicaid plans overlaps with CMS. See Letter on the Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials and State Medical Directors (Jan. 16, 2013) [hereinafter State Health Official Letter], https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SHO-13-001_o.pdf [<https://perma.cc/W57P-675W>].
58. See 29 U.S.C. § 1132(a)(1) (2018).

B. MHPAEA's Cooperative Federalist Framework

We have seen in the preceding Section the MHPAEA's intricate enforcement structure. To explain its unique fragmentation, we must contextualize why it was designed in this manner. In this Section, we argue that the MHPAEA's design reflects a theory of government—cooperative federalism—that was popular at its passage but has since been limited in its usefulness. We first provide a brief overview of the theory and history of cooperative federalism. We then use that history to argue that the MHPAEA comes at an inflection point in the theory of cooperative federalism underlying federal health insurance reform. We return to this theme in Part III, discussing what implications other cooperative federalist statutes have for MHPAEA reform and what these regulatory choices say about the theory more generally.

Until the New Deal, theories of dual federalism that emphasized separate “spheres” of activity reigned in constitutional scholarship.⁵⁹ After the New Deal and World War II, dual-federalism theory was supplanted by intergovernmental-relations theory, otherwise known as cooperative or concurrent federalism theory, which focused on state and federal government cooperation to provide services.⁶⁰

Cooperative federalism rejected concerns about the constitutional propriety of federal government intervention in areas traditionally set aside for the states.⁶¹ It instead emphasized setting a uniform federal floor, over which states have discretion to regulate.⁶² Cooperative federalism is pragmatic, emphasizing

59. See Whittington, *supra* note 18, at 485. See generally Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1 (1950) (cataloguing the fall of dual federalism).

60. Whittington, *supra* note 18, at 485; see also Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and “Dual Sovereignty” Doesn't*, 96 MICH. L. REV. 813, 815 (1998) (calling it “commonplace” to favor cooperative federalism or intergovernmental relations over dual federalism and complicating the distinction); John Shannon & James Edwin Kee, *The Rise of Competitive Federalism*, PUB. BUDGETING & FIN., Dec. 1989, at 5 (“American federalism has veered sharply away from [a] centralizing course towards greater governmental competition.”).

61. Whittington, *supra* note 18, at 485; see also James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for “Cooperative Federalism” to Preserve the States’ Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 452-53 (1994) (arguing that the federal government should assert authority in coordinating a “local-national” health-care policy and that states should help administer and fund it); Elizabeth Weeks Leonard, *Cooperative Federalism and Reform: The Medicare Part D ‘Clawback’ Example*, 1 ST. LOUIS U. J. HEALTH L. & POL’Y 79, 79 (describing the “clawback” as an exemplar of cooperative federalism).

62. See Philip J. Weiser, *Federal Common Law, Cooperative Federalism, and the Enforcement of the Telecom Act*, 76 N.Y.U. L. REV. 1692, 1696 (2001) (“Cooperative federalism programs set

that “spheres” of government can and should collaborate to deliver on policy, in contrast with dual federalism.⁶³ Collaborative programs often leverage the federal government’s constitutional spending power, through which it can condition grants of aid to states on their compliance with stipulated requirements.⁶⁴ This regulatory relationship is often conceived of as a “contract[.]” or a set of “rules governing voluntary, consensual conduct” between states and the federal government.⁶⁵ Under these arrangements, federal financial support serves to “overcome the states’ fiscal limitations [such as] their inability to deficit-spend.”⁶⁶ This is a particularly important function for health-insurance regulation, which must generally operate in a countercyclical fashion to be effective.⁶⁷

The allure of federal financial and infrastructural support drove a surge in cooperative federalism’s popularity between the 1960s and late 1990s, when the MHPA came into existence.⁶⁸ Scholars during this era, especially in the late 1990s, lauded the model’s flexibility and superior enforcement potential.⁶⁹ The theory was particularly instrumental for health-care statutes; Medicaid, authorized in 1965 under Title XIX of the Social Security Act, has been referred to as the “nation’s largest cooperative federalism program.”⁷⁰

forth some uniform federal standards . . . but leave state agencies with discretion to implement the federal law, supplement it with more stringent standards, and, in some cases, receive an exemption from federal requirements.” (footnote omitted)).

63. These latter theories are referred to here as a “dual” approach. See Whittington, *supra* note 18, at 483.
64. U.S. CONST. art. I, § 8, cl. 1; see, e.g., *South Dakota v. Dole* 483 U.S. 203 (1987) (holding that Congress did not exceed its spending powers by conditioning the receipt of five percent of federal highway funds on states’ adoption of a uniform minimum drinking age).
65. James F. Blumstein, *Enforcing Limits on the Affordable Care Act’s Mandated Medicaid Expansion: The Coercion Principle and the Clear Notice Rule*, 2011-2012 CATO SUP. CT. REV. 67, 71.
66. Bagley, *supra* note 33, at 1.
67. See *id.* at 10 (describing the ACA as a “countercyclical spending program,” in that, during a recession, federal insurance programs spend more to cover individuals who lose employer-sponsored insurance after job loss, and that the federal government can cover these spending obligations via deficit spending in ways that a state cannot).
68. See *infra* notes 95-99.
69. See, e.g., Raymond W. Lawton & Bob Burns, *Models of Cooperative Federalism for Telecommunications*, 6 ALB. L.J. SCI. & TECH. 71, 85 (1996) (arguing that the cooperative approach allows states to “apply . . . national standards in a way that best meets the needs and circumstances of their State”); Philip J. Weiser, *Chevron, Cooperative Federalism, and Telecommunications Reform*, 52 VAND. L. REV. 1, 3-4 (1999) (contemplating the benefits of cooperative federalism).
70. Blumstein, *supra* note 65, at 68.

DIVIDE AND CONQUER?

Cooperative federalism continued as a dominant regulatory theory throughout the 1990s and early 2000s.⁷¹ Legal academics described the era as “our contemporary age of cooperative federalism statutory schemes,”⁷² and one law review went so far as to host an entire special issue on cooperative federalism.⁷³ The theory found expression in numerous statutes passed at the time: the Telecommunications Act of 1996 was described as the cooperative federalist descendent of the Communications Act of 1934,⁷⁴ and scholars found cooperative federalist features in the Health Insurance Portability and Accountability Act of 1996,⁷⁵ the Adoption Assistance and Child Welfare Act of 2000,⁷⁶ the Cable Communications Policy Act of 2000,⁷⁷ and “nearly all” of the environmental programs.⁷⁸

Cooperative federalism’s theoretical appeal diminished as Supreme Court decisions in the late 1990s limited provisions that eased the ability for multiple entities to collaborate on enforcement. In particular, these decisions restricted the availability of citizen suits against state regulators,⁷⁹ which to that point had “figure[d] prominently in most cooperative federalism statutes” and which

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71. See John Kincaid, *Trends in Federalism: Is Fiscal Federalism Fizzling?*, in BOOK OF THE STATES 26 (2003). Scholars have suggested this was in part owing to the Republican takeover of Congress in 1995 and the resulting interest in federalism. See Ronald J. Binz, *States as Laboratories: Differing Approaches to the Issue of Federal Preemption of Telecommunications Regulation*, 6 ALB. L.J. SCI. & TECH. 93, 97 (1996).
 72. Weiser, *supra* note 69, at 2-3.
 73. See generally 6 ALB. L.J. SCI. & TECH. (1996) (containing works from Albany Law School’s symposium on the “state role in telecommunications regulation”).
 74. See Lawton & Burns, *supra* note 69, at 81 (arguing that the 1934 Communications Act “explicitly recognized and codified this dual federalism” and identifying the 1996 Telecommunications Act as cooperative); Philip J. Weiser, *Cooperative Federalism and Its Challenges*, 2003 MICH. ST. DCL L. REV. 727, 728 (“During the long reign of the Communications Act of 1934, regulators operated under a dual federalism model that rested on a jurisdictional divide between interstate and intrastate communications. Under the Telecommunications Act of 1996[], however, regulators must conceptualize and implement a cooperative federalism strategy that relies not on a division between, but on a sharing of, federal and state authority.” (footnotes omitted)).
 75. Joseph F. Zimmerman, *National-State Relations: Cooperative Federalism in the Twentieth Century*, 31 PUBLIUS 15, 22 (2001).
 76. Sarah C. Rispin, *Cooperative Federalism and Constructive Waiver of State Sovereign Immunity*, 70 U. CHI. L. REV. 1639, 1642-43 (2003).
 77. *Id.*
 78. *Id.*
 79. See, e.g., *Seminole Tribe v. Florida*, 517 U.S. 44, 74 (1996) (holding that courts should not entertain such suits where the statute lays out a “detailed remedial scheme” for enforcement).

had been hailed by commentators as crucial for gap filling between arms of government.⁸⁰ These precedents continue to hamper the efficacy of cooperative federalist statutes.⁸¹ While it remains a topic of legal scholarship, cooperative federalism as a theoretical framework now receives more mixed reviews by academics.⁸² Commentators have suggested that the theory is too conceptually broad, and that a more nuanced understanding of federalism's operation under a given statute may be appropriate.⁸³

Nevertheless, despite the theoretical controversy, cooperative federalist structures are still utilized in a variety of statutes, particularly those involving health insurance.⁸⁴ Situating the MHPAEA within the history of federal health-insurance regulation helps to elucidate its particular expression of cooperative federalism as well as the need for a more nuanced approach to the theory, in response to the critiques that have called for more measured academic treatment of cooperative federalism.⁸⁵ Medicaid, authorized in 1965 under Title XIX of the Social Security Act, was the first significant cooperative health-insurance program and the prototypical example of a "contract" model of cooperation. Under Medicaid, state expenditures are matched by federal dollars on an un-

80. See Rispin, *supra* note 76, at 1645.

81. See *infra* Section III.A.3.

82. See, e.g., Spencer E. Amdur, *The Right of Refusal: Immigration Enforcement and the New Cooperative Federalism*, 35 YALE L. & POL'Y REV. 87, 118-31 (2016) (explaining how inducement strategies, a form of cooperative federalism, force state governments to participate in immigration enforcement); Ava Ayers, *Discriminatory Cooperative Federalism*, 65 VILL. L. REV. 1, 11-14 (2020) (describing how cooperative federalism and conditional grants can operate to permit states to discriminate against citizens); Silvia Secchi & Moira McDonald, *The State of Water Quality Strategies in the Mississippi River Basin: Is Cooperative Federalism Working?*, 677 SCI. TOTAL ENV'T 241, 249 (2019) (concluding that cooperative federalism has not been effective in addressing water quality issues).

83. See Gluck, *supra* note 33, at 540 ("Statutes like the ACA reveal descriptive gaps . . . [including] that the typically undifferentiated category of 'cooperative federalism' has far more internal nuances than we currently acknowledge.").

84. See, e.g., Bridget A. Fahey, *Health Care Exchanges and the Disaggregation of States in the Implementation of the Affordable Care Act*, 125 YALE L.J.F. 56, 56 (2015) (calling the Affordable Care Act "one of the largest and most complex cooperative programs ever established"); Kirsten H. Engel, *EPA's Clean Power Plan: An Emerging New Cooperative Federalism?*, 45 PUBLIUS 452, 452 (2015) (identifying the 2014 EPA Clean Power Plan as an exemplar of cooperative federalism); Joseph H. Margolies, Note, *Powerful Friends: EPSA, Hughes, and Cooperative Federalism for State Renewable Energy Policy*, 118 COLUM. L. REV. 1425, 1444 (describing new developments in cooperative federalism relating to energy policy).

85. See Gluck, *supra* note 33, at 540 ("Statutes like the ACA reveal descriptive gaps . . . [including] that the typically undifferentiated category of 'cooperative federalism' has far more internal nuances than we currently acknowledge.").

capped basis.⁸⁶ All states opting into Medicaid via a “constitutionally protected voluntary choice”⁸⁷ are given wide discretion to administer their own programs, including the important choice of income and asset thresholds used to define eligibility.⁸⁸

ERISA, the next landmark health-insurance law after Medicaid, enacted in 1975, is an instructive anomaly in federal health-insurance regulatory history. ERISA employs a near-complete preemption of state regulation of employer-based health insurance and is a stark departure from both Medicaid and later cooperative regimes. Scholarly literature suggests that Congress did not anticipate ERISA’s preemptive impact⁸⁹ and the law has been widely criticized as inhibiting innovation in health policy by crowding out state regulatory efforts.⁹⁰ While ERISA inhibited state experimentation, this is precisely what later cooperative-federalist schemes sought to encourage.

HIPAA, passed in 1996, had a significantly more “deferential approach to shared enforcement”⁹¹ than ERISA and a more modest scope than Medicaid. HIPAA, like the MHPAEA, established a federal floor which, among other incremental reforms, prohibited the conditioning of eligibility for group health benefits on preexisting health conditions.⁹² But HIPAA had many problems—for instance, its efficacy was limited because only one insufficiently resourced entity, the Health Care Financing Administration, was tasked with its implementation.⁹³ The MHPAEA, by comparison, spreads enforcement widely across three well-funded federal agencies. HIPAA’s critics also noted a lack of early federal guidance for states, a lack of public education about insurance reform, and the need for federal-state partnership.⁹⁴ Although the MHPAEA has struggled with these same issues, regulatory development and statutory amendments—including the Cures Act—have attempted to address some of

86. See Blumstein, *supra* note 65, at 68.

87. *Id.* at 69 (citing *Printz v. United States*, 521 U.S. 898, 925 (1997)).

88. See Alan Weil, *Promoting Cooperative Federalism Through State Shared Savings*, 32 HEALTH AFF. 1493, 1493-95 (2013).

89. See Carmel Shachar, *The Preemption Clause That Swallowed Health Care: How ERISA Litigation Threatens State Health Policy Efforts*, HEALTH AFF. BLOG (Oct. 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20201013.533063> [<https://perma.cc/Q8PW-T8YR>].

90. See, e.g., Gluck et al., *supra* note 30.

91. See Rosenbaum, *supra* note 33, at 174.

92. See Karen Pollitz, Nicole Tapay, Elizabeth Hadley & Jalena Specht, *Early Experience with “New Federalism” in Health Insurance Regulation*, 19 HEALTH AFF. 7, 8-9 (2000).

93. *Id.* at 15-17.

94. *Id.* at 17-19.

these concerns.⁹⁵ One significant issue which the MHPAEA did not address was the “difficulty [of] imposing national standards on multiple insurance markets,” and neither law went so far as to directly mandate individual coverage.⁹⁶

The MHPAEA comes at an inflection point between the cooperative models of Medicaid and HIPAA and the more dynamic and complex cooperation of the Affordable Care Act (ACA). The ACA, passed shortly after the MHPAEA, marked a shift away from the purely “contractual” approach of Medicaid, the fallback enforcement scheme of HIPAA, and the relatively circumscribed goals of HIPAA and the MHPAEA.⁹⁷ For instance, the ACA, in encouraging a landmark expansion of Medicaid eligibility, attempted to condition the receipt of *all* federal Medicaid matching funds on states’ decisions to expand.⁹⁸ Under the “contract” model of federalism, this was a marked “modification” of the terms that states had agreed to under Medicaid, and was ultimately deemed unconstitutionally coercive in *NFIB v. Sebelius*.⁹⁹

Like HIPAA and the MHPAEA, the ACA also set a federal floor for insurance requirements, in part by establishing “essential health benefits” (EHBs).¹⁰⁰ Unlike the MHPAEA, which significantly constrains state discretion, the ACA leaves it to the states to determine what benefits count as EHBs.¹⁰¹ The ACA further encouraged state innovation via Section 1332 waiv-

95. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).

96. Pollitz et al., *supra* note 92, at 13; *see id.* at 18.

97. For a detailed analysis of federalism under the ACA, *see generally* Gluck, *supra* note 33.

98. *See* Blumstein, *supra* note 65, at 69-70.

99. *Id.* at 74 & n.36 (citing *NFIB v. Sebelius*, 567 U.S. 519, 581 (2012)) (“States have developed intricate statutory and administrative regimes over the course of many decades to implement their objectives under existing Medicaid.”). In another dramatic shift, the ACA also attempted to require that all individuals obtain insurance via a tax penalty, which has been the subject of significant ongoing litigation. *See NFIB*, 567 U.S. at 588 (holding the individual mandate constitutional under Congress’s taxation power but not its Commerce Clause power); *Texas v. United States*, 340 F. Supp. 3d 579, 619 (N.D. Tex. 2018) (holding the individual mandate unconstitutional and inseverable in a decision currently pending on appeal before the Supreme Court), *aff’d in part*, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020) (No. 19-840).

100. Gluck & Huberfeld, *supra* note 33, at 1783-86.

101. *See* Sabrina Corlette, Christine Monahan & Kevin W. Lucia, *Cross-Cutting Issues: Moving to High Quality, Adequate Coverage: State Implementation of New Essential Health Benefits Requirements*, URB. INST. 4-5 (Aug. 2013), <https://www.urban.org/sites/default/files/publication/23896/412882-Moving-to-High-Quality-Adequate-Coverage-State-Implementation-of-New-Essential-Health-Benefits-Requirements.pdf> [https://perma.cc/8J3F-5KWW] (“Rather than define a uniform, national set of essential health benefits,

ers, which allowed states to design their own programs if the coverage provided was essentially similar to that of the ACA itself.¹⁰² Relative to the MHPAEA, the ACA was both a significant step towards comprehensive federal regulation of health insurance and a more potent incentivization of state regulatory action.

The MHPAEA's position in this progression—from a pure “contractual” approach under Medicaid in 1965 to the complex “intrastatutory federalism” of the ACA in 2010—illustrates the evolution of modern cooperative federalism in health care and helps to explain its structure and text.¹⁰³ The various approaches to cooperation under these statutes also highlights the range of regulatory choices cooperative federalist theory can support, varying widely across time even within the same industry and, arguably, the same statute.

C. Textual Ambiguity and the Scope of Protections

The complex web of enforcement and interpretive authority created by a cooperative federalism model creates opportunities for inconsistency. This tendency is only exacerbated when the underlying statutory language is ambiguous. Although the enforcement structure of the MHPAEA has not meaningfully changed since 2010, significant attempts have been made over the last decade to clarify the law's protections and expand its scope. Reform efforts have also focused on clarifying the extent of cooperation between federal and state actors.

In Sections I.C.1 and I.C.2, we describe the impact of the ACA and the Cures Act, along with various regulatory guidance, on the MHPAEA's development. The ACA and various regulations passed within the first five years of the MHPAEA's existence attempted to clarify and expand the parity law, the result of which was more people covered by the MHPAEA but still under unclear terms. The Cures Act was the next and, at the time of writing, last congression-

HHS provided that each state could choose a benchmark plan on which to base their EHB package.”).

102. A “waiver” is a formal grant of permission from the federal government for a state to deviate from provisions of federal law. They are sometimes subject to additional reporting and other requirements. Waivers are often used to encourage state experimentation and to tailor nationwide policies to local needs. See, e.g., Heather Howard & Galen Benshoof, *Section 1332 Waivers and the Future of State Health Reform*, HEALTH AFF. BLOG (Dec. 5, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20141205.043142> [<https://perma.cc/F6S2-2NF5>] (describing the goals of 1332 waivers); Robert W. Seifert, Rachel Gershon & Katharine London, *How Waivers Work: ACA Section 1332 and Medicaid Section 1115*, CONN. HEALTH FOUND. (Oct. 30, 2015), <https://www.cthealth.org/wp-content/uploads/2015/10/R2T-Policy-Briefs-2.0-How-Waivers-Work-final.pdf> [<https://perma.cc/4CQY-W6XR>] (explaining the mechanics of ACA Section 1332 waivers, including additional requirements).

103. See generally Gluck, *supra* note 33 (proposing the idea of “intrastatutory federalism”).

al salvo against lingering ambiguity. Despite defining more ambiguous terms and giving marching orders for ongoing interagency cooperation and transparency, enforcement remains low.

1. *Infancy: The MHPAEA from 2010 to 2015*

Widespread confusion about the MHPAEA's scope of protections arose shortly after its enactment. This confusion was generated by ambiguous statutory language laying out the MHPAEA's parity requirements, the statute's tri-agency joint interpretive authority, and the inherent difficulty of comparing MH/SUD to M/S benefits.¹⁰⁴ Although HHS, DOL, and the Treasury released interim final regulations clarifying the scope of protections in February 2010, they were not finalized until November 2013.¹⁰⁵ To aid in cross-benefit comparison, the interim regulations established six categories of benefits: in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency care, and prescription drugs.¹⁰⁶

The regulations then defined the ambiguous statutory terms “predominant” and “substantially all,” which are crucial to defining and evaluating parity.¹⁰⁷ A plan may not impose a QTL applicable to MH/SUD benefits that is more restrictive than the predominant QTL applied to substantially all M/S benefits in the same classification.¹⁰⁸ Under this test, an enforcement agency “[f]irst determine[s] if . . . [the] QTL applies to ‘substantially all’—two thirds—of “[M/S] benefits in the relevant classification of benefits.”¹⁰⁹ It “then determine[s] the predominant amount”—the dollar amount applying to more than half of M/S benefits—of that QTL. Copayment for MH/SUD benefits in

104. See, e.g., Joni Roach, *supra* note 28, at 270 (noting that “it is difficult to achieve actual insurance parity because of the inherent differences between mental and physical illnesses” and that this difficulty is compounded by federal agencies’ failures to “uniformly or specifically define[] key terms such as “mental illness”).

105. See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68,240 (Nov. 13, 2013) (to be codified at Treas. Reg. pt. 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 146, 147).

106. *Id.* at 68,241 & n.4 (making note of the interim regulations’ classifications); *id.* at 68,243 (stating that the final guidelines would keep the classifications from the interim guidelines).

107. *Id.* at 68,243.

108. *Id.* at 68,242.

109. See *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*, U.S. DEP’T LAB. 15 (Oct. 2020) [hereinafter *Self-Compliance Tool*], <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf> [<https://perma.cc/HA6U-SQXY>].

the same class can be no higher than that amount.¹¹⁰ For NQTLs, such as preauthorization requirements or medical-necessity determinations, the plan or issuer is required to utilize the same “processes, strategies, evidentiary standards, and other factors” used for M/S benefits of the same classification.¹¹¹ The final regulations also included an illustrative list of the types of limitations that might qualify as NQTLs.¹¹²

It was initially unclear whether the MHPAEA requirements would apply to Medicaid and CHIP plans, in part because CMS lagged in issuing regulations. As of 2013, CMS had issued a state health official letter of guidance,¹¹³ and it formally proposed regulations for implementing the MHPAEA two years later.¹¹⁴ These regulations had language very similar to those proffered by the November 2013 joint regulations and did not take effect until 2017. Because a large number of people who depend upon Medicaid require MH/SUD care, the delay substantially limited the early reach of the MHPAEA.¹¹⁵

The scope of federal mental-health parity laws received a boost in 2014 from the ACA. The ACA defined MH/SUD benefits as “essential,” such that many individual and small-group market plans must now offer MH/SUD benefits.¹¹⁶ The extension of these benefits has meant that parity requirements now apply broadly to plans previously regulated in a patchwork manner at the state level.¹¹⁷ Moreover, the ACA expanded coverage—notably including a

110. *Id.*

111. *Id.* at 4; *see id.* at 9.

112. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. at 68,272 (to be codified at Treas. Reg. § 54.9812-1(c)(4)(ii)).

113. *See* State Health Official Letter, *supra* note 57.

114. *See* Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18,389 (Mar. 30, 2016) (codified at 42 C.F.R. pts. 438, 440, 456, 457).

115. *See* Goodell, *supra* note 31.

116. *See* Kirsten Beronio, Rosa Po, Laura Skopec & Sherry Glied, *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans*, U.S. DEP’T HEALTH & HUM. SERVS. (Feb. 20, 2013), <https://aspe.hhs.gov/report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-62-million-americans> [<https://perma.cc/CX45-5KU4>].

117. *See* *Making Health Care Better*, WHITE HOUSE 8 (2016), https://obamawhitehouse.archives.gov/sites/default/files/docs/mental_health_and_suicide_prevention_report_9-28-16.pdf [<https://perma.cc/4JDP-22EJ>].

range of MH/SUD benefits subject to parity requirements—to an estimated twenty-seven million previously uninsured individuals.¹¹⁸

2. *Slow Growth: The MHPAEA from 2015 to the Present*

Although the ACA greatly expanded the number of individuals benefitting from the protections of the MHPAEA, it did little to address the interpretation and enforcement issues that typified earlier implementation efforts. The federal government has since attempted to clarify remaining ambiguities and streamline interagency coordination through the Cures Act, enacted in December 2016, and a variety of guidance documents. Concurrently, some states expanded consumer education and enforcement efforts, including landmark settlements in New York and Massachusetts. Despite these attempts, many of the early problems remain and rigorous enforcement efforts are the exception.

The Cures Act is the only federal legislation since the ACA to comprehensively address the MHPAEA.¹¹⁹ The Cures Act and related guidance were intended to streamline cooperation among federal and state agencies. The Cures Act also contained provisions to further clarify parity requirements, enhance consumer and industry awareness of these requirements, and increase reporting of ongoing enforcement efforts.¹²⁰ In order to facilitate these goals, the Cures Act mandated that HHS hold a Parity Public Listening Session to receive feedback on compliance issues and ideas for improving implementation and enforcement of the MHPAEA.¹²¹ The results of this listening session, held in July 2017, were published in an Action Plan released in April 2018.¹²²

Most of the action items included in the Plan were related to previously identified issues with the MHPAEA, many of which were acknowledged by the Cures Act itself. For example, the Plan acknowledged the difficulty of appropri-

118. These benefits included preventive screening and counseling, free of copayments or deductibles, for conditions like alcohol misuse, depression, and domestic violence. *See id.* at 5. This expansion included children under twenty-six who were able to remain on their parents' plans. *See* Beronio et al., *supra* note 116.

119. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).

120. *Id.*

121. § 13001(a), 103 Stat. at 1278.

122. *See* Assistant Sec'y for Pub. Affairs, *21st Century Cures Act: Section 13002, Action Plan for Enhanced Enforcement of the Mental Health and Substance Abuse Disorder Coverage*, U.S. DEP'T HEALTH & HUM. SERVS. (Apr. 30, 2018), <https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/21st-century-cures-act-section-13002/index.html> [<https://perma.cc/D5PV-5VQ2>].

ately defining and recognizing NQTLs.¹²³ Each responsible federal agency had previously released its own guidance regarding the definition and scope of parity protections. The Centers for Medicare and Medicaid Services released a list of “[w]arning [s]igns”—NQTL provisions that may indicate lack of parity compliance.¹²⁴ These warning signs included provisions regarding blanket preauthorization for all MH/SUD services, requirements that patients fail less intensive therapies before escalating care (“[f]ail-first protocols”), and requiring written treatment plans for MH/SUD care.¹²⁵ The DOL also published a number of Frequently Asked Questions (FAQs) that provided more examples and further clarified the scope of parity protections and requirements.¹²⁶ These FAQs clarify that experimental MH/SUD therapies are covered by the MHPAEA and that plans may exclude all benefits for a particular condition.¹²⁷

To encourage both interpretive consistency and insurer awareness of clarifications of the MHPAEA requirements, the Cures Act mandates that federal agencies jointly publish a biennial “[c]ompliance program guidance document” including detailed examples of both compliance and noncompliance.¹²⁸ This document has taken the form of a detailed “self-compliance tool,” most recently published in 2020, that offers tips, examples, and detailed discussion of the MHPAEA provisions.¹²⁹

For consumers, the Cures Act provides a model form for requesting documentation concerning treatment limits from employer-sponsored health

123. *Id.*

124. *Warning Signs—Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) That Require Additional Analysis to Determine Mental Health Parity Compliance*, U.S. CTRS. MEDICARE & MEDICAID SERVS. (Jun. 2016), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/MHAPAEAChecklistWarningSigns.pdf> [<https://perma.cc/3ZDQ-M7FU>].

125. *Id.*

126. For links to all FAQs and other applicable guidance, see *Mental Health and Substance Use Disorder Parity*, U.S. DEP’T LAB. (2020), <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity> [<https://perma.cc/B8AW-643Z>].

127. See *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39*, U.S. DEP’T LAB. (Sept. 5, 2019), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf> [<https://perma.cc/K8WY-6SHC>].

128. 21st Century Cures Act, Pub. L. No. 114-255, § 13001(a), 103 Stat. 1033, 1278 (codified in scattered sections of 42 U.S.C.).

129. See *Self-Compliance Tool*, *supra* note 109.

plans.¹³⁰ The Cures Act also authorized creating a single toll-free telephone number and a parity website to assist consumers in directing their complaints to the appropriate state or federal agency.¹³¹ To further encourage the solicitation of consumer complaints and subsequent enforcement, the Cures Act included a number of new reporting requirements related to federal enforcement efforts.¹³² EBSA must prepare an annual report detailing investigations closed in the previous year along with violations found and their subject matters.¹³³ The Government Accountability Office (GAO) must also prepare a report on industry-wide compliance with parity requirements.¹³⁴ Despite the proliferation of clarifying guidance and attempts at streamlining cooperative enforcement, the GAO has suggested that rates of both federal enforcement and consumer complaints remain low.¹³⁵ This decline will be further explored in Part II.

D. State Mental-Health Parity Laws

Although the MHPAEA, coupled with federal preemption by ERISA, Medicare, and Medicaid, marked an historic shift toward the federal regulation of health insurance, state mental-health parity laws have continued to play an important, albeit limited, role in the parity landscape. As displayed in Table 1, states retain default issuer-level regulatory authority over the individual and group markets when not otherwise preempted. They may also regulate non-ERISA plans above the floor set by the MHPAEA and may choose to regulate a variety of plans not covered by the Act.¹³⁶ As of 2017, every state but Wyoming

130. *Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations*, U.S. DEP'T LAB. (Apr. 2018), <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft-revised.pdf> [<https://perma.cc/JVN2-YC96>].

131. § 13002(c)(5)(B), 130 Stat. at 1284.

132. *Id.*

133. *Id.* § 13003.

134. *Id.* § 13004.

135. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-150, *supra* note 44, at 42. The Cures Act is relatively recent and a number of critical guidance documents, like the self-compliance tool, were released in 2018. Therefore, the effectiveness of its reforms is difficult to assess at present. Increasing federal enforcement and stakeholder involvement are important to measure the ongoing clarity of the law; trends in violation types may indicate related interpretive issues that could be corroborated by industry outreach.

136. MHPAEA requirements do not apply to a number of plans amenable to state regulation, including “grandfathered” individual and group health plans that were purchased before March 23, 2010; plans exempted because of an increase in parity-related costs; self-funded

had some form of law relating to mental-health coverage,¹³⁷ and thirty-seven states had a mental-health parity law, in particular.¹³⁸ Overall, state insurance law directly impacts approximately 26.6% of covered Americans.¹³⁹

Though they may not directly impact all Americans, state laws are often broader in scope than the MHPAEA.¹⁴⁰ Some statutes define “mental illness,” a definition conspicuously absent from the MHPAEA, which has precipitated a number of interpretative problems.¹⁴¹ In states with such laws, there is often tension over whether to define “mental illnesses” as including any condition in the Diagnostic and Statistical Manual of Mental Disorders or to limit the scope to “biologically based mental illnesses.”¹⁴² State parity laws also require particular benefits via a variety of provisions. “Mandated-benefit” statutes require insurers to satisfy a minimum standard for mental-health coverage by providing stipulated benefits.¹⁴³ On the other hand, “mandated-offering” laws require

small employer plans; short-term, limited duration, and alternative insurance plans; and self-insured state and local government plans that opt-out. See *State Attorney General Parity Act Enforcement Toolkit*, PARITY 10, at 4 (Jan. 26, 2019), http://parityat10.org/wp-content/uploads/2019/03/ParityAt10_AG-Toolkit_FINAL-citation-added.pdf [https://perma.cc/2KKS-K4D2].

137. See Megan Douglas et al., *Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report*, KENNEDY F. 4 (2018), <https://wellbeingtrust.org/wp-content/uploads/2019/06/evaluating-state-mental-health-report-wbt-for-web.pdf> [https://perma.cc/LY6U].
138. See Berry et al., *supra* note 47, at 1066.
139. See Douglas et al., *supra* note 137, at 5.
140. See *Mental Health Benefits: State Laws Mandating or Regulating*, NAT’L CONF. ST. LEGISLATURES (Dec. 30, 2015), <https://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> [https://perma.cc/XQN3-QR3E] (noting that there is “no federal law directly mandating parity to the same extent as state laws”).
141. See, e.g., Roach, *supra* note 28, at 269 (arguing that HHS’s failure to specifically define “mental illness” as it related to ACA provisions “will likely result in the continued arbitrary application of mental-health-parity laws from state to state”).
142. See generally Heller, *supra* note 31, at 583 (highlighting that New York defines a mental-health condition as one that results from a “biological disorder of the brain,” as compared with Georgia and Connecticut, which have more expansive definitions tied to the Diagnostic and Statistical Manual of Mental Disorders (quoting 2006 N.Y. Laws 748)). The Diagnostic and Statistical Manual of Mental Disorders is the authoritative source used by mental-health providers to define and classify mental disorders. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5) (2013).
143. Mandated benefits are the most common type of mandate in state parity laws. See Shamash, *supra* note 30, at 290 n.71. For an example of a mandated-benefit statute, see CONN. GEN. STAT. ANN. § 38a-514(a) (West 2020), which provides that “each group health insurance policy providing coverage . . . shall provide benefits for the diagnosis and treatment of mental or nervous conditions.”

that insurers offer at least one plan that meets defined criteria.¹⁴⁴ And “mandated if offered” statutes require that, if the insurer offers mental-health coverage, the plan must meet baseline requirements, such as treating MH/SUD benefits similar to M/S benefits.¹⁴⁵

Finally, states may or may not offer exemptions to any of the above parity requirements. Common exemptions in state parity laws include those for small employers or other employers who experience significant cost increases as a result of offering mental-health coverage or parity, mirroring exemptions in the MHPAEA itself.¹⁴⁶ To add to the complexity, even when two state statutes contain identical language, courts in each state may interpret them in divergent ways, resulting in differing scopes of protections.¹⁴⁷ Although state parity laws do not regulate as many plans as federal law, they inject enormous complexity into the parity landscape.¹⁴⁸ At its best, variation in state laws allows for more comprehensive protections and enhanced enforcement above the federal floor. On the other hand, variation in state laws can frustrate enforcement efforts at both the state and federal levels.

Having explored the cooperative federalist structure and history of the MHPAEA, we use Part II to examine empirical data about the effectiveness of state, federal, and private efforts to enforce it.

144. See, e.g., GA. CODE ANN. § 33-24-28.1(b) (2020) (providing that “every insurer . . . shall be required to make available, either as a part of or as an optional endorsement to all . . . policies providing major medical insurance coverage . . . [and] coverage for the treatment of mental disorders”); see also Shamash, *supra* note 30, at 290 n.72 (identifying GA. CODE ANN. § 33-24-28.1(b) (2020), ALA. CODE § 27-54-3 (2020), and MO. ANN. STAT. § 376.1550 (West 2020) as mandated-offering statutes).

145. See Shamash, *supra* note 30, at 290. For an example of a “mandated if offered” statute, see KY. REV. STAT. ANN. § 304.17A-661(1) (West 2020), which provides that “a health benefit plan . . . that provides coverage for treatment of a mental health condition shall provide coverage of any treatment for a mental health condition under the same terms or conditions as provided for treatment of a physical health condition.”

146. See Melissa M. McGow, *A Plan for Recovery: Steps to Finally Provide Adequate Insurance Coverage for Those Starving for It the Most*, 15 ROGER WILLIAMS U. L. REV. 583, 607-09 (2010).

147. See Shamash, *supra* note 30, at 279-80; see also Jessica A. Scarbrough, *The Growing Importance of Mental Health Parity*, 44 AM. J. L. & MED 453, 460 (2018) (“[E]ven when the language [in state mental-health parity laws] appeared similar in the statutes, state legislatures and courts interpreted them differently than other states.”).

148. See, e.g., *State Insurance Mandates and the ACA Essential Benefits Provisions*, NAT’L CONF. ST. LEGISLATURES (Apr. 12, 2018), <https://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx> [<https://perma.cc/NM9M-4F8G>].

II. DIVIDED ENFORCEMENT UNDER THE MHPAEA: DATA AND CASE STUDIES

Due to the significant clarification and coordination efforts undertaken by the federal government since 2010 and the additional protections provided by state parity laws, one might expect robust enforcement of parity requirements under the MHPAEA. However, the limited enforcement data available from EBSA and HHS indicate that federal-enforcement efforts decreased markedly from 2011 to 2019. Across the same period, states varied widely in their enforcement efforts, and some achieved landmark settlements related to mental-health parity violations. These findings suggest that state enforcement can have advantageous effects within the mental-health parity landscape.

A. Federal Enforcement

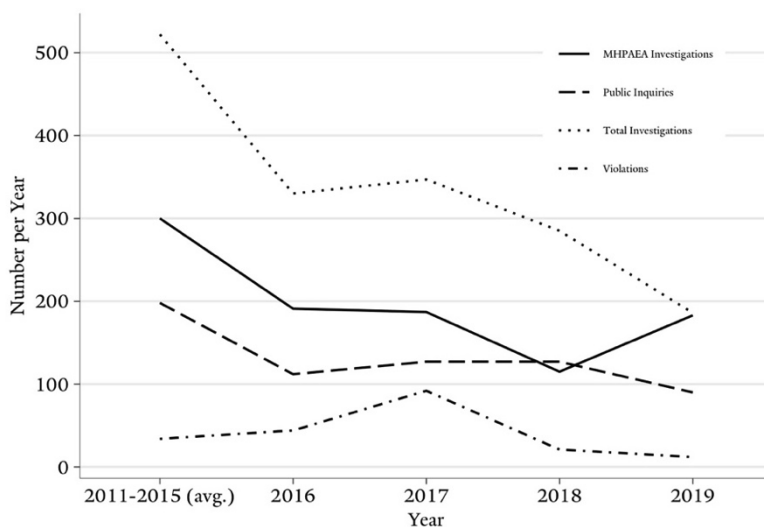
As previously described, DOL, HHS, and the Treasury jointly enforce parity requirements for the majority of U.S. insurance plans. In 2019, EBSA oversight covered approximately 2.4 million plans with 135 million participants.¹⁴⁹ Despite this enormous responsibility, EBSA employs only 400 investigators responsible for both MHPAEA- and non-MHPAEA-related violations—one investigator for every 6000 insurance plans.¹⁵⁰ That EBSA closes a relatively small number of investigations each year—just 186 in FY 2019¹⁵¹—is not surprising in light of these staffing constraints and the enormous complexity of conducting each investigation. As Figure 1 illustrates below, the total number of investigations closed each year and the number of investigations related to the MHPAEA have declined significantly since FY 2011-2015.

149. See EMP. BENEFITS SEC. ADMIN., *supra* note 52, at 1.

150. *Id.*

151. *Id.* at 3.

FIGURE 1.
EBSA ENFORCEMENT AND PUBLIC INQUIRY TRENDS FROM FY 2011 TO FY 2019¹⁵²



As one 2019 GAO report noted, EBSA and HHS both rely heavily on complaints from the public to identify targets for investigation.¹⁵³ The decline in public inquiries noted in the EBSA Reports highlights the need for more prospective auditing and target-identification mechanisms. At the very least, renewed proactive federal outreach and public educational efforts are necessary.

The types of violations observed by EBSA across time are also useful for understanding the efficacy of the Cures Act and associated guidance. As noted in Figure 2, NQTL violations remain a significant problem despite the proliferation of guidance intended to clarify permissible and impermissible limitations.

152. Data from 2011-2015 are only reported by EBSA as an aggregate sum, so they are reported here as an annual average over the five fiscal years. Detailed annual reporting began in 2016, secondary to the requirements of the Cures Act. See EMP. BENEFITS SEC. ADMIN., *supra* note 52; EMP. BENEFITS SEC. ADMIN., *FY 2018 MHPAEA Enforcement*, U.S. DEP'T LAB. [hereinafter EMP. BENEFITS SEC. ADMIN., *FY 2018 MHPAEA Enforcement*], <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2018.pdf> [https://perma.cc/U8MF-3XVW]; EMP. BENEFITS SEC. ADMIN., *MHPAEA Enforcement Fact Sheets*, U.S. DEP'T LAB. [hereinafter EMP. BENEFITS SEC. ADMIN., *MHPAEA Enforcement Fact Sheets*], <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement> [https://perma.cc/ZC]9-NWB3] (linking to fact sheets for FY 2010-2017).

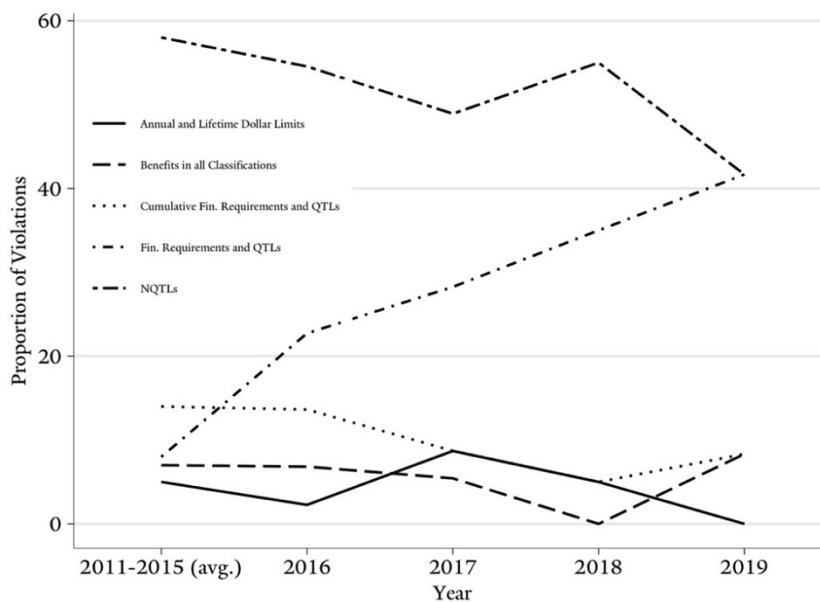
153. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-150, *supra* note 44.

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Despite the clear guidance for discerning financial requirements and QTLs, these violations have only increased since its issuance.

FIGURE 2.

MHPAEA VIOLATION BREAKDOWN BY YEARS, FY 2011-FY 2019¹⁵⁴



HHS enforcement, although more limited in jurisdictional scope than EBSA enforcement, illustrates many of the same trends. CMS has released only three years of enforcement reports detailing only ten completed investigations and one market-conduct examination since FY 2016 – too limited a sample for drawing trend inferences. As described above, the vast majority of investigations were triggered by complaints received by CMS.¹⁵⁵ In FY 2016, three of the four investigations carried out were related to NQTLs, including a precertification requirement, a fail-first policy, and an age limitation.¹⁵⁶ The fourth investigation was secondary to an invalid opt-out related to HIPAA require-

¹⁵⁴. See EMP. BENEFITS SEC. ADMIN., *supra* note 52; EMP. BENEFITS SEC. ADMIN., *FY 2018 MHPAEA Enforcement*, *supra* note 152; EMP. BENEFITS SEC. ADMIN., *MHPAEA Enforcement Fact Sheets*, *supra* note 152.

¹⁵⁵. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-20-150, *supra* note 44.

¹⁵⁶. See Department of Health and Human Services (HHS) *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Enforcement Report: Current as of December 2017*, U.S. DEP'T HEALTH & HUM. SERVS. 2 (Dec. 2017), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HHS-2008-MHPAEA-Enforcement-Period.pdf> [<https://perma.cc/JG2G-CXWX>].

ments.¹⁵⁷ The single investigation and one market-conduct examination conducted in FY 2017 were both related to NQTLs, including a coverage exclusion and a preauthorization requirement.¹⁵⁸ In FY 2018, three investigations were completed, all of which related to invalid HIPAA opt-outs.¹⁵⁹ And although two investigations were completed in FY 2019, no MHPAEA violations were found.¹⁶⁰ As with EBSA enforcement, the CMS reports suggest overreliance on consumer complaints to determine targets for investigations, a high proportion of violations related to NQTLs, and overall low levels of enforcement.

Both EBSA and CMS rely heavily on voluntary compliance in remediating the MHPAEA violations. EBSA investigators typically require plans to “remove any non-compliant provisions and pay any improperly denied benefits.”¹⁶¹ Under current law, EBSA cannot assess civil monetary penalties, and equitable relief is limited to reimbursement for denials of past claims.¹⁶² In cases where the plan or issuer is not willing to correct the issue voluntarily, the case must be referred to the Office of the Solicitor for subsequent litigation—and there is no guarantee that such litigation will be prioritized or pursued.¹⁶³

B. State Enforcement

States, like the federal government, enforce the MHPAEA in an inconsistent fashion that further underscores the disjointed nature of the law’s cooperative structure. As shown in Table 1, states retain primary enforcement authority over the MHPAEA with respect to health-insurance issuers in the individual and group markets; they also share authority over CHIP, Medicaid-managed care, and Medicaid Alternative Benefit plans.¹⁶⁴ The federal govern-

157. *Id.*

158. *Id.* at 3.

159. See Department of Health and Human Services (HHS) *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Enforcement Report: For the 2018 Federal Fiscal Year*, U.S. DEP’T HEALTH & HUM. SERVS. 3 (2018), <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/FY2018-MHPAEA-Enforcement-Report.pdf> [<https://perma.cc/NS7B-FBQX>].

160. See EMP. BENEFITS SEC. ADMIN., *supra* note 52, at 4.

161. *Id.* at 5.

162. See *Pathway to Full Parity*, U.S. DEP’T LAB. 7 (2018), <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf> [<https://perma.cc/WH5W-M5KM>].

163. *Id.* at 10.

164. See State Health Official Letter, *supra* note 57, at 3-6.

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ment retains the ability to intervene and assume any of these enforcement responsibilities if states “fail to substantially enforce” the MHPAEA.¹⁶⁵

Similar to the multi-agency regime at the federal level, states enforce mental-health-parity laws through a variety of entities.¹⁶⁶ States require both insurance plans and issuers to be licensed, typically with Departments of Insurance (DOIs), prior to doing business in the state.¹⁶⁷ Other states have separate regulatory authorities for certain types of insurance, such as California’s Department of Managed Health Care.¹⁶⁸ Some states, particularly those with strong consumer-protection statutes such as Massachusetts and New York, rely heavily on state attorneys general to enforce both state and federal mental-health parity laws, as discussed below. The choice of primary enforcement agency is an important one; in Massachusetts, for instance, the DOI can only levy fines and revoke licensures, while the AG can invoke criminal liability and conduct large investigations.¹⁶⁹ Similarly, states may direct consumer complaints to different agencies, with complaints about fraud or misrepresentation generally directed to the state’s AG and those concerning scope of benefits to the DOI.¹⁷⁰

The overall level of parity enforcement varies widely among states. At one end, Missouri, Oklahoma, Texas, and Wyoming have opted out of enforcing federal parity requirements and have ceded enforcement authority to CMS.¹⁷¹ Other states, including Alabama, Louisiana, Florida, Montana, and Wisconsin, maintain collaborative enforcement agreements with CMS, such that the states enforce the federal requirements and only refer investigations to CMS if they are unable to obtain compliance.¹⁷² In all states, the federal government retains back-up authority over states that fail to substantially enforce the MHPAEA, but it is unclear whether or not this authority has been asserted despite state enforcement efforts that often appear underwhelming.¹⁷³ Of note, this “back-

165. EMP. BENEFITS SEC. ADMIN., *supra* note 52, at 1.

166. *See State Attorney General Parity Act Enforcement Toolkit*, *supra* note 136, at 2.

167. *See Noonan & Boraske*, *supra* note 28, at 257.

168. *See generally 2019 Annual Report*, CAL. DEP’T MANAGED HEALTHCARE (2020), <https://www.dmh.ca.gov/Portals/0/Docs/DO/2019ARFinalAccessible.pdf> [<https://perma.cc/L36F-4C5R>] (describing the Department’s work).

169. *See, e.g., Sarah Gordon Chiramida, Understanding the Massachusetts and Federal Mental Health Parity Laws*, MASS. ASS’N HEALTH PLANS 6 (Apr. 2016), https://www.mahp.com/wp-content/uploads/2017/05/MAHP_OnPoint_April2016_Mental-healthParity.pdf [<https://perma.cc/E3UW-HKE2>].

170. *See id.*

171. *See* EMP. BENEFITS SEC. ADMIN., *supra* note 52, at 1.

172. *Id.*

173. *Id.*

up” jurisdiction mirrors the Telecommunications Act of 1996, under which the Federal Communications Commission (FCC) enforces the statute by developing interconnection agreements in states that have declined to enforce the Act.¹⁷⁴

Despite the complex jurisdictional structure and variable level of enforcement efforts, some state-enforcement actions highlight the opposite approach—aggressive enforcement resulting in landmark agreements with remedies far exceeding those of federal enforcement or private litigation. The ability of states to draw on consumer-protection statutes and state parity laws enables them to step outside of their limited enforcement authority under the MHPAEA and to expand available remedies. Because of the tremendous variation in state-enforcement structures, case studies of two states with recent, high-profile enforcement successes, Massachusetts and New York, are useful in illustrating notable characteristics of successful states’ enforcement practices.¹⁷⁵

Massachusetts and New York have been chosen as case studies because they are the two states with the most recent and largest enforcement actions.¹⁷⁶ Both states also augment their enforcement efforts by way of state consumer-

174. See 47 U.S.C. § 252(e)(5) (2018); see also Weiser, *supra* note 69, at 19 n.71 (“Thus far, no state agency has refused to assume the role provided to it in the Telecom Act.”).

175. A 2017 settlement in California also represents the power of a proactive enforcement agency and the flexibility of solutions available at the state level. As determined by the State of California, Kaiser Health “failed to ensure effective action is taken to improve care where deficiencies are identified in service elements, including accessibility, availability, and continuity of care.” Stipulated Settlement Agreement, Kaiser Foundation Health Plan, Inc., No. 15-082, at 4 (Dep’t Managed Health Care Cal., July 18, 2017), <https://wpso.dmhc.ca.gov/enfactions/docs/2895/1602861252108.pdf> [<https://perma.cc/FE66-JS8U>]. The California Department of Managed Health Care investigated Kaiser Health for four years over its violations of state and federal parity laws, issuing repeated cease-and-desist orders and notices of compliance failure. In 2017, California entered the above settlement agreement with Kaiser Health. The agreement stipulated that Kaiser would bear the cost of an independent consultant to monitor them for up to three years. *Id.* at 9-11. It imposed procedures accounting for changes in parity laws and for negotiating impasses via the independent consultant. *Id.* at 6-7, 10. Moreover, it imposed civil monetary penalties for future deficiencies between \$75,000 and \$100,000. *Id.* at 14-15. Importantly, many of the stipulations agreed upon in the settlement, such as the independent monitor, are not available remedies under the MHPAEA and suggest a unique role for states in remedying parity violations.

176. See *State Parity Regulatory Enforcement Actions, Fall 2020*, PARITYTRACK (2020), <https://www.paritytrack.org/resources/state-parity-enforcement-actions> [<https://perma.cc/34RW-DH6D>]. At the time of writing, the Illinois settlement had not yet taken place. Massachusetts and New York were chosen for extended case studies over California because their settlements were larger, both in monetary value and number of insurance companies involved: California’s settlement was \$850,000 and focused on a single insurer, while Massachusetts’s was over \$1 million and involved seven insurers, and New York’s was over \$2 million in penalties extracted from five insurers.

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protection statutes. Massachusetts's investigations and settlements were all conducted by the Office of the Attorney General (AGO), as were New York's. These settlements all rely on consumer-protection statutes for their remedies, which are generally broader than those achievable by DOL, HHS, or Treasury enforcement.

1. *Case Study in Successful State Parity Enforcement: Massachusetts*

Recent parity agreements reached by the Massachusetts AGO illustrate the power of states in enforcing mental-health parity laws. These agreements were reached using both federal and state law. For example, the Assurance of Discontinuance (AOD) reached with Blue Cross and Blue Shield of Massachusetts specified that the investigation was conducted under all three federal laws amended to create the MHPAEA: the Public Health Service Act, ERISA, and the Internal Revenue Code.¹⁷⁷

In addition, that investigation relied on two state laws, Massachusetts's consumer-protection statute and the Acts of 2014, which expanded the AGO's scope even beyond the text of the MHPAEA. The state consumer protection statute allows Massachusetts to target unfair and deceptive business practices, which empowered the AG to address inaccuracies in provider directories, even though the MHPAEA makes no mention of the issue.¹⁷⁸ Chapter 258 of the Acts of 2014, another Massachusetts-specific law, grants broad authority to revise NQTLs for SUDs, including the prior authorization and utilization-review practices targeted in a number of the AODs.¹⁷⁹

177. See *Blue Cross Blue Shield AOD*, OFFICE MASS. ATT'Y GEN. 1 (2020), <https://www.mass.gov/doc/blue-cross-blue-shield-aod/download> [<https://perma.cc/8FRT-CT34>]. The federal Code sections relied upon were 42 U.S.C. § 300gg-26, 29 U.S.C. § 1185a, and I.R.C. § 9812.

178. See MASS. GEN. LAWS ch. 93A (2019).

179. See 2014 Mass. Acts 1012.

TABLE 2.
DETAILS OF MASSACHUSETTS PARITY AGREEMENTS SINCE 2019¹⁸⁰

Plan	Violation(s)	Remedy
AllWays	Inaccurate provider directories (non-MHPAEA), provider reimbursement rates (financial requirement), utilization management (NQTL)	<u>February 2020</u> : (i) improve accuracy, detail, and transparency of provider directories, including via audits; (ii) track and monitor complaints regarding directory accuracy; (iii) align reimbursement rate methodology and report any changes to the AGO; (iv) eliminate prior authorization for inpatient treatment; (v) clarify and equalize utilization management, and report to the AGO; (vi) pay penalty of \$175,000.
Blue Cross Blue Shield	Inaccurate provider directories (non-MHPAEA), limit coverage for acute treatment and clinical stabilization from out-of-state providers (benefit exclusion/QTL)	<u>February 2020</u> : (i) improve accuracy, detail, and transparency of provider directories, including via audits; (ii) track and monitor complaints regarding directory accuracy; (iii) cover medically necessary acute treatment and clinical stabilization without preauthorization for fourteen days; (iv) pay penalty of \$210,000.
Fallon/Beacon	Inaccurate provider directors (non-MHPAEA), provider reimbursement rates (financial requirement), utilization management (NQTL)	<u>February 2020</u> : (i) improve accuracy, detail, and transparency of provider directories, including via audits; (ii) track and monitor complaints regarding directory accuracy; (iii) align reimbursement-rate methodology and report any changes to the AGO; (iv) eliminate prior authorization for inpatient treatment; (v) clarify and equalize utilization management, and report to the AGO; (vi) pay penalty of \$125,000.

¹⁸⁰. For all Massachusetts agreements, see *Attorney General's Office Behavioral Health Parity Agreements*, OFF. MASS. ATT'Y GEN. (2020), <https://www.mass.gov/lists/attorney-general's-office-behavioral-health-parity-agreements> [<https://perma.cc/JXJ9-F95G>].

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<p>Harvard Pilgrim/Optum</p>	<p>Inaccurate provider directories (non-MHPAEA), provider reimbursement rates (financial requirement), utilization management (NQTL)</p>	<p><u>February 2020</u>: (i) improve accuracy, detail, and transparency of provider directories, including via audits; (ii) track and monitor complaints regarding directory accuracy; (iii) align reimbursement rate methodology and report any changes to the AGO; (iv) clarify and equalize utilization management, and report to the AGO; (v) pay penalty of \$275,000.</p>
<p>Tufts Health Plan</p>	<p>Inaccurate provider directories (non-MHPAEA)</p>	<p><u>February 2020</u>: (i) improve accuracy, detail, and transparency of provider directories, including via audits; (ii) track and monitor complaints regarding directory accuracy; (iii) pay penalty of \$125,000.</p>

The February 2020 agreement with AllWays illustrates the potential for these AODs to exceed federal remedies under the MHPAEA.¹⁸¹ AllWays was alleged to have violated the MHPAEA by imposing unequal financial requirements via lower provider-reimbursement rates for MH/SUD, by applying stricter utilization management to MH/SUD cases than medical/surgical cases, and by providing incomplete or inaccurate provider directories to consumers.¹⁸² Its agreement bound AllWays to pay a penalty of \$175,000 and subjected the company to periodic audits while the company improves the detail and transparency of its provider directories.¹⁸³ The company also agreed to track and monitor complaints regarding directory accuracy in the future.¹⁸⁴ The company was required to eliminate prior authorization for inpatient treatment, align its reimbursement-rate methodology for MH/SUD and M/S benefits, and clarify and equalize its utilization-management policies for these benefits.¹⁸⁵ These stipulations align with the requirements of the federal the MHPAEA. The monetary penalty and auditing requirements are largely a function of Massachusetts’s consumer-protection law and the enforcement capabilities of the Massachusetts AGO. Therefore, the combination of federal and state law was crucial in achieving the breadth and prospective effect of this AOD.

181. See Assurance of Discontinuance Pursuant to G.L. Chapter 93A, §5, Commonwealth v. AllWays Health Partners Inc., (Mass. Dist. Ct. Feb. 27, 2020).

182. *Id.* at 7-9.

183. *Id.* at 18-19, 26.

184. *Id.* at 11-12.

185. *Id.* at 19-26.

2. Case Study in Successful State Parity Enforcement: New York

As in Massachusetts, New York's enforcement experience shows the ability of state AGs to creatively enforce parity requirements. New York has adopted a multipronged strategy reflecting the need for consumer education. This included the creation of a Health Care Bureau Helpline, a toll-free hotline managed by qualified intake specialists who can direct complaints and offer mediation of disputes related to behavioral health-insurance claims.¹⁸⁶

Moreover, New York, like Massachusetts, leverages both state and federal laws to pursue a wider range of insurance company conduct than the MHPAEA alone addresses. New York's parity law, known as Timothy's Law, takes a mandated-if-offered approach, requiring group health plans providing coverage for inpatient hospital care or physician services to provide mental-health coverage that is at least equal to that of other medical conditions.¹⁸⁷ The law also requires that utilization review be applied consistently across all covered services¹⁸⁸ and that policies providing comprehensive coverage must cover inpatient and outpatient SUD treatment.¹⁸⁹ The power of these statutes is evident in the agreements reached by New York, many of which are related to utilization review, residential treatment, and SUD coverage.

Armed with multiple enforcement tools, the NYAG reached large parity-related settlements, with wide-ranging stipulations. As described in Table 3 below, the state has entered into eight agreements with seven major insurers since 2013, garnering \$3 million in penalties and returning \$2 million to over 300 consumers for falsely denied claims.¹⁹⁰

186. See Health Care Bureau, *Mental Health Parity: Enforcement by the New York State Office of the Attorney General*, N.Y. STATE OFF. ATT'Y GEN. 1 (May 2018) [hereinafter *NYAG Enforcement Report*], https://ag.ny.gov/sites/default/files/hcb_mental_health_parity_report.pdf [<https://perma.cc/W2U9-GAU7>].

187. N.Y. INS. LAW §§ 3221(l)(5)(A), 4303(g)(1) (Consol. 2020).

188. 2006 N.Y. LAWS § 3717.

189. N.Y. INS. LAW §§ 3216(i)(31), 3221(l)(7)(A), 4303(l)(1) (Consol. 2020).

190. See *NYAG Enforcement Report*, *supra* note 186, at 1.

DIVIDE AND CONQUER?

TABLE 3.
DETAILS OF NEW YORK PARITY AGREEMENTS SINCE 2013¹⁹¹

Plan	Violation(s)	Remedy
MVP	Utilization review (NQTL), exclusion of residential treatment (benefit exclusion), co-payments (financial limitation)	<u>March 2014</u> : (i) cover residential treatment; (ii) reform behavioral health utilization review process (including by issuing detailed denial letters to members); (iii) charge equal copays for outpatient behavioral health visits and primary care visits; (iv) appoint an internal compliance monitor for at least two years; (v) provide opportunity for appeals to members who received medical necessity denials within four years; (vi) pay a penalty of \$300,000.
EmblemHealth	Utilization review (NQTL), exclusion of residential treatment (benefit exclusion), co-payments (financial limitation)	<u>July 2014</u> : (i) cover residential treatment; (ii) reform behavioral health-utilization review process (including by issuing detailed denial letters to members); (iii) charge equal copays for outpatient behavioral health visits and primary care visits; (iv) appoint an internal compliance monitor for at least two years; (v) provide opportunity for appeals to members who received medical necessity denials within four years; (vi) pay a penalty of \$1.2 million.
Beacon Health Options	Utilization review (NQTL), exclusion of residential treatment (benefit exclusion), co-payments (financial limitation)	<u>March 2015</u> : (i) abide by the terms of the MVP/EmblemHealth agreements; (ii) cooperate with the compliance administrators of those agreements; (iii) cease discounting psychotherapy administered by non-physicians; (iv) appoint external claims administrator for the EmblemHealth appeals process; (v) pay penalty of \$900,000.
Excellus	Utilization review and fail-first requirement for inpatient SUD services (NQTL), exclusion of residential treatment (benefit exclusion), co-payments (financial limitation)	<u>March 2015</u> : (i) eliminate fail-first requirements; (ii) cover residential treatment for behavioral-health conditions; (iii) equalize copayments; (iv) provide opportunity for limited retrospective appeals before an independent entity; (v) appoint an internal compliance monitor; (vi) pay penalty of \$500,000.

191. *Id.* at 4-8.

HealthNow	Exclusion of nutritional counseling for eating disorders (benefit exclusion), prior authorization for outpatient psychotherapy after 20 visits but not for medical treatment (NQTL)	<u>August 2016</u> : (i) cover nutritional counseling; (ii) remove 20-visit threshold; (iii) reimburse individuals who received denials because of these limitations, and who paid out of pocket for the treatment.
Cigna	Limit of three visits to nutritional counselor per year for mental-health conditions (QTL), prior authorization for MAT drugs (NQTL)	<u>January 2014</u> : (i) eliminate three-visit limit; (ii) provide restitution for those denied; (iii) pay penalty of \$23,000. <u>October 2016</u> : (i) remove prior authorization requirements.
Anthem	Prior authorization for MAT drugs (NQTL)	<u>January 2017</u> : (i) remove prior authorization requirements; (ii) launch MAT initiative to increase network provider-base capacity.

The Excellus settlement is emblematic of New York's approach. In 2015, the NYAG determined that Excellus was violating both state and federal parity laws by excluding residential treatment for behavioral-health conditions, charging higher copayments for behavioral-health services than for comparable medical-health services, and conducting stricter utilization review for inpatient SUD health services than for medical services.¹⁹² This last finding stemmed from Excellus's "fail first" requirements for inpatient SUD treatment and its higher denial rate for this service compared to inpatient medical services.¹⁹³ Due to the investigation, Excellus agreed to cover residential treatment for behavioral-health conditions, eliminate fail-first requirements for inpatient SUD rehabilitation, and equalize copayments for behavioral-health visits with those for primary care.¹⁹⁴ It also agreed to comply with an appeals procedure that relied on an independent entity to assess medical-necessity denials, adopt an internal compliance monitor for at least two years, and pay \$500,000 in penalties.¹⁹⁵ The NYAG was able to achieve reforms not available under the MHPAEA, such as the new appeals procedure, thus exceeding the reach of federal enforcement.¹⁹⁶

192. *Id.* at 4.

193. *Id.*

194. *Id.*

195. *Id.*

196. *Id.*

The 2017 Anthem/Empire BlueCross BlueShield settlement also highlights novel ways that state AGs can pursue parity through settlements, both in their state and nationally.¹⁹⁷ The NYAG found that Anthem required prior authorization for MAT for opioid use disorder.¹⁹⁸ Because of the limited number of authorized providers in its network, prior authorization required individuals struggling with opioid use disorder to wait for long periods to access their medication.¹⁹⁹ In the settlement, Anthem agreed to remove prior authorization for oral MAT drugs nationwide, not just in New York.²⁰⁰ It also removed prior authorization for an injectable MAT drug, naltrexone, in New York and launched an effort to improve its in-network MAT provider capacity.²⁰¹

New York's aggressive enforcement tactics may have been effective for achieving parity in individual plans. Excellus reported a 15% absolute decrease in denial rates for mental-health residential treatment (from 33% to 18%), a 19.20% absolute decrease in denials for SUD detox (from 20.20% to 1.00%), and an astounding 49% absolute decrease in denials for residential SUD treatment (from 50.00% to 1.00%) from 2015 to 2017.²⁰² Another plan, Emblem-Health, reported more accuracy in denials and increased specificity in denial decisions across the same period.²⁰³ Finally, data from 2018 shows that, after the 2014 settlement with MVP, there was a decrease in denial rates and an increase in spending for (and thus the utilization of) behavioral health.²⁰⁴

3. *Conclusions: State Settlements Extend the Reach of the MHPAEA*

As illustrated by the case studies of New York and Massachusetts, state laws influence both the scope of parity violations targeted and the remedies achieved—often in ways that exceed the ambit of the MHPAEA. These state agreements impart lessons regarding the allocation of enforcement authority between federal and state actors under the MHPAEA. Most noticeably, states

197. *Id.* at 5.

198. See NYAG *Enforcement Report*, *supra* note 186, at 5.

199. *Id.*

200. *Id.*; see also Letter from Eric T. Schneiderman, N.Y. Attorney Gen. to Anthem, Inc. & Empire BlueCross BlueShield 1 (Jan. 17, 2017), https://ag.ny.gov/sites/default/files/final_letter_agreement_anthem-empire_mat_010117.pdf [<https://perma.cc/G3GK-HG3E>] (memorializing Anthem's agreement to remove prior authorization).

201. *Id.*

202. See NYAG *Enforcement Report*, *supra* note 186, at 7.

203. *Id.* at 6.

204. *Id.*

that fully utilize their enforcement power rather than yield it to CMS can achieve more comprehensive remedies than CMS. This illustrates the potential payoff of a cooperative scheme. Because of the involvement of state AGOs, which harness the threat of broad enforcement authority under consumer-protection laws, state-level settlements often permit more creativity in prospective relief, such as the appointment of independent monitors, wholesale alteration of existing practices, and the creation of new initiatives. This is in stark contrast to private litigation, which is typically limited to restitution for denied claims, and to federal enforcement, which typically involves fines or cessation of violative practices. States are often better able to solicit and direct consumer complaints via established helplines like those in New York and Massachusetts, and they may be more aware of local or regional conditions relevant to complainants.²⁰⁵

205. Some insurance carriers' settlements with states have involved nationwide changes in conduct, despite state AGs relying in part on state laws for their claims. See generally *Attorney General's Office Behavioral Health Parity Agreements*, *supra* note 180. Because of the possibility of nationwide relief, commentators have debated the merits of federal authorities' supervising state AGs as they negotiate settlements that implicate federal laws. See, e.g., Elysa M. Dishman, *Enforcement Piggybacking and Multistate Actions*, 2019 BYU L. REV. 421, 428-31 (2020) (arguing that state AGs are best understood as acting horizontally alongside other enforcement actors, such as federal and private actors); Margaret H. Lemos, *Forward: State Enforcement in a Federal World*, 2019 BYU L. REV. 1427, 1432, 1438-46 (2020) (acknowledging partisanship among AGs but suggesting this is not inherently harmful, and later reviewing normative suggestions for harmonizing federal and state actors in dual enforcement of federal law); Margaret H. Lemos, *State Enforcement of Federal Law*, 86 N.Y.U. L. REV. 698, 717-41 (2011) [hereinafter *State Enforcement of Federal Law*] (casting state enforcement of federal law as a vehicle of state control, which thereby permits state AGs to define the intensity of enforcement or direct policy); Mark Totten, *Credit Reform and the States: The Vital Role of Attorneys General After Dodd-Frank*, 99 IOWA L. REV. 115, 129-32, 142-65 (2013) (noting that Title X requires state AGs to notify the Consumer Finance Protection Bureau before initiating action and reserves the Bureau's right to intervene in state enforcement); Amy Widman & Prentiss Cox, *State Attorneys General's Use of Concurrent Public Enforcement Authority in Federal Consumer Protection Laws*, 33 CARDOZO L. REV. 53, 55 (2011) (acknowledging ever-increasing politicization of state AGs but debunking fears of inconsistent enforcement of federal law by empirically demonstrating that state AGs enforce federal laws consistently). In the case of state mental-health parity settlements, state AGs may enforce both state and federal parity laws. We believe that, in this context, requiring federal supervision of state AG settlements would impede enforcement without significant benefit. First, such settlements are generally negotiated in cooperation with the insurer and are entered into voluntarily (of course, with a looming threat of litigation). Many nationally applicable terms would likely be agreed to because the company views them as in its best interest, such as preserving good will among its customers or staving off subsequent state or federal litigation. Furthermore, nationally applicable terms help to gap-fill lackluster enforcement in less-aggressive states, and preserve federal and state enforcement resources—strengthening the MHPAEA's cooperative-enforcement framework.

Nevertheless, even in states with relatively aggressive enforcement, disparities in utilization patterns and reimbursement rates persist. In Massachusetts, out-of-network utilization rates have skyrocketed, and the disparity between utilization rates for out-of-network M/S benefits and behavioral-health benefits is higher than the national average.²⁰⁶ From 2013 to 2017, out-of-network utilization for MH/SUD inpatient facilities increased from 2.15 times to 10.49 times that of M/S inpatient facilities.²⁰⁷ Reimbursement rates of primary-care physicians increased in Massachusetts from 51.0% higher than behavioral health in 2013 to 59.6% higher in 2017.²⁰⁸ Analogous rates have been observed in New York.²⁰⁹ Disparities in other states may be far greater given how few have strong parity laws like New York or Massachusetts—in fact, the Kennedy-Satcher Center for Mental Health Equity gave 43 states a D or an F letter grade in 2018 based on the strength of their parity legislation.²¹⁰

A 2018 analysis of five states with a variety of state parity laws and enforcement tactics has attempted to explain inadequate enforcement and inconsistent results.²¹¹ It found that all five states suffered from a lack of effective complaint processes and enforcement tools, with overreliance on reactive enforcement and penalties that are not always harsh enough to compel compliance.²¹² Moreover, consumers and providers in all five states lacked awareness of what conduct constituted a parity violation, underscoring the ambiguity of the federal law despite the proliferation of clarifying guidance.²¹³ Consumers in particular have less access than state enforcers to information from carriers to uncover whether their rights have been violated.²¹⁴ As with any administrative-enforcement regime, prosecutorial discretion, resource constraints, and political capital may contribute to underenforcement by states.²¹⁵

206. See MELEK ET AL., *supra* note 20, at 103-04.

207. *Id.* at 54.

208. *Id.*

209. *Id.* at 65 (showing the behavioral out-of-network inpatient utilization rate rising from 5.84 to 10.38 times that of M/S, and the primary-care reimbursement gap rising from 8.1% to 17.7%).

210. See Douglas et al., *supra* note 137, at 10-11.

211. See Vuolo, *supra* note 34.

212. *Id.*

213. *Id.*

214. *Id.*

215. See generally *State Enforcement of Federal Law*, *supra* note 205 (comparing differing incentives and behavior of state and federal agencies in enforcing federal law).

Disparities between the scope of state legal protections and the vigor of state enforcement efforts demonstrate the need for some level of federal involvement to achieve the goal of comprehensive mental-health parity. However, the unique abilities of states to reach creative prospective settlements suggest that, when not preempted from doing so, states should retain primary enforcement authority over the plans they directly regulate. As discussed in Section II.C below, future reform should focus on federal priority-setting and incentivization of state action, prioritizing federal enforcement for those states who refuse to or cannot enforce the MHPAEA.

C. Private Enforcement

Private enforcement of the MHPAEA requirements has been relatively limited over the past decade, although a handful of high-profile cases helped to clarify the law's protections early in its history.²¹⁶ Private rights exist under the MHPAEA only for those governed by ERISA and with a claim against their insurer; nowhere in the MHPAEA are there grounds for private suits against state or federal regulators.²¹⁷ One study found that, between 2005 and 2015, only thirty-seven private suits against insurers had been brought pursuant to the MHPAEA and state parity laws, excluding those that were settled or for which no judgment was reached.²¹⁸

Those individuals wishing to bring private parity suits against their insurers do so under the general disclosure provision of ERISA.²¹⁹ First, a private plaintiff may request information about the processes, strategies, evidentiary standards, or other factors the issuer used to apply an NQTL on their bene-

216. See generally Berry et al., *supra* note 47 (analyzing lawsuits pertaining to the MHPAEA and related state parity laws).

217. See 29 U.S.C. § 1132 (2018); *American Psychiatric Ass'n v. Anthem Health Plans*, 50 Supp. 3d 157, 161 (D. Conn. 2014) ("Although there is no private right of action under the Parity Act, portions of the law are incorporated into ERISA and may be enforced using the civil enforcement procedures in ERISA § 502, to the extent that they apply."). It is possible, however, that some affirmative decisions reached by federal agencies pursuant to the MHPAEA would be reviewable under the Administrative Procedure Act (APA), although underenforcement would be challenging to target, and insurers themselves would not be reached directly. See *Douglas v. Indep. Living Ctr.*, 565 U.S. 606, 614 (2012) (suggesting that healthcare providers seek review of Centers for Medicare & Medicaid Services decisions under the APA rather than via a Supremacy Clause challenge).

218. See Berry et al., *supra* note 47, at 1074 (noting that the authors' "final sample included thirty-seven cases"). *But see id.* at 1072 (noting that the study's methodology does not "reach cases that are settled before they come before a judge").

219. See 29 C.F.R. § 2520.104b-1 (2005).

fits.²²⁰ This step is crucial in bridging the information gap between private plaintiffs and government enforcement agencies, which often receive such information secondary to statutory-reporting requirements or request it during investigations. If the issuer fails to respond within 30 days, it may incur a penalty of \$110 per day past the due date, which is imposed by a court.²²¹

Private litigation has had qualified success in identifying and correcting compliance gaps.²²² An analysis of thirty-seven state and federal cases found that twenty-five concerned coverage exclusions, such as denial of care in certain practice settings, and thirteen concerned disputes over covered benefits, such as financial and medical-necessity limitations.²²³ Seven cases brought claims solely under the MHPAEA, twenty-six brought claims solely under state parity laws, and the remaining four cases invoked both.²²⁴ The study identified six recurring themes in state and federal private-parity suits.²²⁵ The first is the scope of coverage guaranteed under parity laws; disputes over denials of residential treatments comprise a plurality of these cases.²²⁶ A second topic of litigation is the nature of therapies covered, such as whether nonrestorative therapies and developmental or educational services are included under the category of mental-health benefits and are therefore subject to parity.²²⁷ The four other themes of private-parity litigation include insurers' method of applying credentialing requirements for providers, determinations of medical necessity, and the

220. See U.S. DEP'T LABOR, IMPROVING HEALTH COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER PATIENTS: INCLUDING COMPLIANCE WITH THE FEDERAL MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY PROVISIONS 11 (2016), <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/improving-health-coverage-for-mental-health-and-substance-use-disorder-patients.pdf> [https://perma.cc/5W2L-RJCD]; see also *Self-Compliance Tool*, *supra* note 109, at 21-22 (providing a list of the information that individuals may request).

221. See *Self-Compliance Tool*, *supra* note 109, at 29.

222. See Berry et al., *supra* note 47, at 1092 ("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.").

223. *Id.* at 1076-78.

224. *Id.* at 1074.

225. *Id.* at 1079.

226. *Id.* at 1079-83.

227. *Id.* at 1083-84. Because a number of states only ensure parity for mental illnesses that are "biologically based," private litigation in these states commonly disputes insurers' classifications of the plaintiffs' illnesses as not being "biologically based." See Shamash, *supra* note 30, at 301 n.116.

MHPAEA's intersection with insurance laws and regulatory actions by agencies.²²⁸

Litigation has limited utility in federal enforcement, given that private actions under the MHPAEA typically seek retroactive remedies for prior denials of benefits rather than prospective reform.²²⁹ Individual enforcement suffers from the same problems as other enforcement mechanisms that depend upon consumer complaints – notably, consumers have asymmetric information about their rights and fewer resources at hand. Its true value, however, lies in increasing aggregate enforcement efforts and involving the court system to achieve compliance.²³⁰ Private litigation also empowers the large number of Americans whose health insurance is regulated by ERISA to augment the state and federal framework by enforcing their own rights.²³¹

III. A DREAM UNREALIZED: LESSONS ON COOPERATIVE FEDERALISM AFTER THE FIRST DECADE OF THE MHPAEA

Despite numerous attempts to clarify the MHPAEA and a decade of enforcement efforts, mental-health parity remains an elusive goal. A recent nationwide report showed that, in 2017, use of both inpatient and outpatient behavioral facilities occurred out-of-network more than five times as often as use of medical or surgical facilities.²³² The report also showed a significant disparity in reimbursement rates for both primary care providers and medical/surgical specialists compared to behavioral providers.²³³ In 2017, primary-care provider reimbursement rates were 23.8% higher than behavioral provider reimbursement rates.²³⁴ This disparity in reimbursement increased from 2013 to 2017 and the gap is significantly larger for reimbursement of substance-use-disorder cases.²³⁵

228. See Berry et al., *supra* note 47, at 1086–90.

229. See *generally id.* (examining a sample of thirty-seven private lawsuits under the MHPAEA and state parity laws).

230. See *id.* at 1094.

231. In at least one district, providers can also bring suits on behalf of patients, and plan administrators can be held liable for damages. See, e.g., *N.Y. State Psychiatric Ass'n v. United Health Grp.*, 980 F. Supp. 2d 527 (S.D.N.Y. 2013).

232. See Melek et al., *supra* note 20, at 6.

233. *Id.* at 6–7.

234. *Id.*

235. *Id.*

Higher costs and limited access to MH/SUD care likely contribute to the significant number of untreated individuals with mental illness. Only 43.1% of adults with mental illness received mental-health services in 2015, an increase of less than 1% from 2010.²³⁶ And despite a surge in opioid use over the last decade, only 12.1% of adults aged 26 or older with SUD received specialty substance-use treatment in 2015.²³⁷

Structural complexity and lackluster enforcement of the MHPAEA requirements are significant obstacles to remedying disparities in MH/SUD coverage. To date, the few reform efforts that have attempted to streamline oversight have failed to significantly improve enforcement. Critics have argued that, while federal parity laws have expressive value, the emphasis on cooperative enforcement greatly undermined their effectiveness, leaving insurers with many methods through which to limit a patient's effective coverage while still complying with federal requirements.²³⁸ Nevertheless, many commentators have recently defended the cooperative-federalism framework as flexible, results-oriented, and ultimately more responsive to the public's needs.²³⁹ Legislators, too, have recently drawn on variations of cooperative federalist frameworks in recent health-insurance reform,²⁴⁰ suggesting that cooperative federalism continues to be a dominant theoretical framework for federal health-insurance reform.

236. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 25.

237. *Id.*

238. See, e.g., Richard G. Frank, Chris Koyanagi & Thomas G. McGuire, *The Politics and Economics of Mental Health 'Parity' Laws*, 16 HEALTH AFF. 108, 110-11, 115-18 (1997); William Goldman, Joyce McCulloch & Roland Sturm, *Costs and Use of Mental Health Services Before and After Managed Care*, 17 HEALTH AFF. 40, 48-51 (1998); Ching-to Albert Ma & Thomas G. McGuire, *Costs and Incentives in a Behavioral Health Carve-Out*, 17 HEALTH AFF. 53, 54-56, 67-68 (1998).

239. See, e.g., Lawton & Burns, *supra* note 69, at 85-88 (arguing that the cooperative approach allows states to "apply . . . national standards in a way that best meets the needs and circumstances of their State" and that, when a federal standard is clear, states will set their own provisions allowing the delivery to be functionally similar, even if details vary by state); Weiser, *supra* note 69, at 31-38 (explaining the purposes of cooperative federalism); Weiser, *supra* note 74, at 729 (listing the benefits of cooperative federalism); *Federalism Task Force Report: Cooperative Federalism and Telecom in the 21st Century*, NAT'L ASS'N REG. UTIL. COMMISSIONERS 11 (Nov. 2013), <https://pubs.naruc.org/pub.cfm?id=oD53064E-9E9C-0929-9D01-FDBF631704F5> [<https://perma.cc/WBA7-L5RS>].

240. Notably, the ACA expanded the reach of federal law by applying parity requirements to individual and small-group plans, which were regulated solely by states under the MHPAEA. It also required that states choosing to expand their Medicaid programs ensure that Alternative Benefit Plans comply with parity requirements. See Megan Douglas et al., *supra* note 135; see also *supra* Section 1.B (discussing the ACA).

In light of the structural and empirical analysis of the MHPAEA detailed above, the following Sections unpack structural elements of successful non-health insurance cooperative statutes on which the MHPAEA reform can be modeled.

A. Lessons from Other Experiments in Cooperative Federalism

This Section explores cooperative federalist statutes from other industries, focusing particularly on the Telecommunications Act of 1996²⁴¹ and the Public Utility Regulatory Policies Act of 1978.²⁴² It explores how the MHPAEA might stand to benefit by incorporating some of their successful features. As compared to the MHPAEA, these statutory schemes are designed to involve actors at all levels of government and within industry to enhance democratic participation.²⁴³ The availability of private rights of action also helps to increase enforcement.²⁴⁴

1. Transparency and Open Participation: Public Evidentiary Hearings

The Public Utilities Regulatory Policies Act of 1978 (PURPA) creates multiple channels through which stakeholders other than federal regulators can voice their opinions. For instance, PURPA mandates that, before state commissioners set energy policy, they must hold public evidentiary hearings comparing the policy with the congressional floor set by PURPA.²⁴⁵ Any utility company or consumer may participate so long they have been affected by the subject at issue.²⁴⁶ To encourage participation, PURPA provides a grant pro-

241. Pub. L. No. 104-104, 110 Stat. 56 (1996) (codified as amended in scattered sections of 47 U.S.C.).

242. Pub. L. No. 95-617, 92 Stat. 3117 (1978) (codified as amended in 16 U.S.C. § 2601).

243. Lawton & Burns, *supra* note 69, at 87; *see also* 16 U.S.C. § 2631 (2018) (establishing a framework for regulator and stakeholder participation in regulatory proceedings); Robert E. Burns & Mark Eifert, *The National Regulatory Research Institute, A White Paper on the Energy Policy Act of 1992: An Overview for State Commissions of New PURPA Statutory Standards*, NAT'L REG. RES. INST. 2-3 (1993), <https://ipu.msu.edu/wp-content/uploads/2016/12/Burns-Eifert-White-Paper-PURPA-Standards-93-6-Apr-93-1.pdf> [<https://perma.cc/2XME-J8Z7>] (discussing the various provisions of PURPA).

244. *See* Rispin, *supra* note 76, at 1645-46.

245. 15 U.S.C. §§ 3203(a), (c) (2018). Though states are free to revise or even reject the congressional standard so long as they hold the public evidentiary hearing in a timely manner and permit all qualifying parties to participate, actual deviance from the congressional standard tends to be minimal. *See* Lawton & Burns, *supra* note 69, at 85-86.

246. *See* Lawton & Burns, *supra* note 69, at 87; *see also* 16 U.S.C. § 2631 (2018).

gram whereby the Secretary of Energy provides states with money to assist qualifying parties with preparing presentations or testimonials for public evidentiary hearings.²⁴⁷ This ensures that state policies are grounded in evidence and appropriate for the needs of the regulated community.²⁴⁸

The multiple chances for community participation in PURPA contrasts with the MHPAEA's labyrinthine information flow. Federal MHPAEA enforcement has historically relied on consumer complaints, though the public listening session and public-oriented FAQ-generation provided in the Cures Act has since brought the MHPAEA more closely in line with the spirit of PURPA.²⁴⁹ That said, this annual session does not approximate the degree of transparency and open communication provided by other cooperative statutes. Federal regulators within EBSA, HHS, and DOL should increase the frequency of listening sessions and create more accessible channels for state regulators, insurers, and consumers to participate. Moreover, consumer education remains an enduring problem under the MHPAEA. The federal agencies responsible for the MHPAEA must view consumer education as a prerequisite to reliance on consumer-triggered enforcement mechanisms – and should invest accordingly.

2. *Transparency and Open Participation: Joint Boards*

MHPAEA could also promote transparency via novel ways of sharing information inspired by other cooperative federalist statutes. For instance, sections 410 and 254 of the Telecommunications Act create Joint Boards to help arbitrate disputes, make recommendations, and provide policy insights.²⁵⁰ Each of the Boards consists of three FCC commissioners, four state commissioners, and, in one Board, one consumer advocate.²⁵¹ Each Board exists for a dedicated purpose, either implementing the Act's general mandates or managing the separation of expenses between intrastate and interstate jurisdictions.²⁵²

247. 42 U.S.C. §§ 6805(a), 6807(a), 6808 (2018).

248. See Lawton & Burns, *supra* note 69, at 86 (“Evidentiary hearings ensure that information and data submitted will receive fair consideration, and that the conclusions reached will be supported by data.”).

249. *Id.*

250. 47 U.S.C. §§ 254, 410(a)-(b) (2018); see also *Federalism Task Force Report: Cooperative Federalism and Telecom in the 21st Century*, *supra* note 239, at 4 (noting the FCC's work with Joint Boards to provide solutions to problems); Lawton & Burns, *supra* note 69, at 83 (describing the issue-resolving purpose of Joint Boards under the federal statute).

251. 47 U.S.C. §§ 254(a), 410(c) (2018).

252. See Lawton & Burns, *supra* note 69, at 83; *Federalism Task Force Report: Cooperative Federalism and Telecom in the 21st Century*, *supra* note 239, at 4.

The Act also explicitly authorizes the FCC to create more Boards, though only one has been created since.²⁵³ Before taking action on any matter covered by sections 410 and 254 of the Telecommunications Act, the FCC must first refer the proceeding to the relevant Board.²⁵⁴ The Board then deliberates and makes a recommendation to the FCC.²⁵⁵ While the Board does not exercise independently binding authority, it does ensure that the FCC's decisions are guided by real-world experience and that members involved at multiple stages of oversight are sharing information with each other.²⁵⁶

Boards also advise the FCC in its rulemaking.²⁵⁷ Like many agencies, the FCC primarily relies upon informal notice-and-comment rulemaking to pursue its mandate.²⁵⁸ The FCC has traditionally given special attention to the Boards during the rulemaking process.²⁵⁹ Board advice promotes rulemaking informed by a spectrum of regulators and consumer advocates, similar to the function served by PURPA's public evidentiary hearings. Just as the public evidentiary hearings in PURPA help state commissioners set energy policy, the Telecommunications Act-created Boards ensure that the FCC sets policy based in evidence and the experience of both the regulated community and commissioners at all levels.²⁶⁰ This helps to ensure collaboration between the FCC and state governments in protecting consumers and meeting their needs, and it promotes the Act's aims of competition and universal availability of service.²⁶¹

Boards under the Telecommunications Act provide useful lessons for reforming the MHPAEA. They exemplify the values of cooperative federalism by folding federal, state, and even industry officials into a single entity. The Cures Act also mandated that the three federal agencies involved in MHPAEA-enforcement collaborate on regular reports.²⁶² However, this tri-agency body did not have a significant role beyond publishing their biennial "compliance

253. 47 U.S.C. § 410(c) (2018); see Lawton & Burns, *supra* note 69, at 83.

254. See Lawton & Burns, *supra* note 69, at 83.

255. See *id.*

256. See *id.*; *Federalism Task Force Report: Cooperative Federalism and Telecom in the 21st Century*, *supra* note 239, at 6.

257. See *id.* at 6-7.

258. See *id.* at 7.

259. Some examples include revisions to the Lifeline program, certification of eligible telecommunications carriers (ETCs), cost allocations, and wholesale service requirements. See *id.*

260. See Lawton & Burns, *supra* note 69, at 86.

261. See *id.*

262. See *supra* Section I.C.2 (discussing the Cures Act).

program guidance document” and any associated self-compliance tools.²⁶³ The Cures Act also failed to encourage the three agencies or state regulators to collaborate on policy formation in the manner of the Telecommunications Act’s boards. Coordinated enforcement, particularly the creation of subject-specific task forces for particular insurance plan types or violations (for example, NQTLS) similar to the Boards, could lead to more efficient and uniform enforcement.

In terms of federal-state collaboration, the Telecommunications Act has another advantage over the MHPAEA: it identifies only one federal agency, the FCC, to serve as the touch point for state agencies, while the MHPAEA tasks three with nominally separate areas of jurisdiction that often overlap. Boards combining EBSA, Treasury, and HHS officials could allow the three agencies to together communicate and coordinate with states. Although the precise design of such entities is beyond the scope of this Note, we suspect that state officials could promote information transfer and vigorous enforcement if they were given advisory roles in federal-enforcement proceedings. Alternatively, a Board responsible for interpretation could be the sole point of contact for states with respect to clarifications of the law. Under any reform proposal, the goal should be to reduce federal-level interpretive and enforcement-related fragmentation, as well as to enhance and formalize communication among state regulators, industry stakeholders, and consumers.

3. *Enhanced Enforcement: Private Rights of Action*

MHPAEA’s lack of private enforcement opportunities against state regulators appears particularly questionable when considering the crucial role such enforcement has played in other cooperative federalist statutes.²⁶⁴ Private enforcement opportunities “figure prominently in most cooperative federalism statutes,”²⁶⁵ as “the threat of citizen suits will motivate regulators to carry out their mandates and take action against violators.”²⁶⁶ Such suits can also prevent capture of agencies by interest groups and seek resolution for violations that states might not be able to identify.²⁶⁷ Supreme Court precedent permits Con-

263. *See id.*

264. *See* Rispin, *supra* note 76, at 1644-46.

265. *Id.* at 1645-46.

266. *Id.*

267. *Id.*

gress to render states amenable to private suit in a federal court,²⁶⁸ either by states constructively waiving their immunity or, in the case of laws passed pursuant to Article I of the Constitution, directly abrogating their immunity.²⁶⁹ Non-health insurance cooperative federalist statutes have made liberal use of private suits as tool of enforcement.²⁷⁰ For example, the Telecommunications Act of 1996 provides that “any party aggrieved by [a state’s determination] may bring an action in an appropriate Federal district court to determine whether the agreement or statement meets the requirements of [the Act].”²⁷¹ Citizen suit provisions, granting standing to those beyond the regulated community to bring suit against state or federal officials enforcing federal laws, also feature prominently in cooperative federalist statutes passed between the 1960s and late 1990s.²⁷²

MHPAEA’s lack of private rights of action against state enforcement agencies, in contrast with other cooperative statutes, may be explained at least in part by changes in Supreme Court jurisprudence limiting their availability. In

268. *Id.* at 1646 nn.40-41 (discussing *Parden v. Terminal Railway of Alabama Docks Department*, 377 U.S. 184, 192-93 (1964), which found that Alabama had consented to suit and constructively waived immunity by operating a railroad in interstate commerce after Congress had rendered this action amenable to suit; and *Pennsylvania v. Union Gas Co.*, 491 U.S. 1, 19-20 (1989), which found that the Commerce Clause granted Congress the power to abrogate state sovereign immunity, given that the Article I power to regulate interstate commerce would be “incomplete without the authority to render States liable in damages”).

269. U.S. CONST. amend. XI; *see also Union Gas Co.*, 491 U.S. at 19-20 (allowing a state to be sued).

270. *See Rispin, supra* note 76, at 1644.

271. 47 U.S.C. § 252(e)(6) (2018).

272. *See Rispin, supra* note 76, at 1645 (discussing function of these suits in the Clean Air Act); *see also* Cass R. Sunstein, *What’s Standing After Lujan? Of Citizen Suits, “Injuries,” and Article III*, 91 MICH. L. REV. 163, 165 n.11 (1992) (noting that “[e]very major environmental statute except FIFRA authorizes a citizen suit” and listing statutes in which Congress used the citizen suit “as a mechanism for controlling unlawfully inadequate enforcement of the law,” including the Toxic Substances Control Act (codified at 15 U.S.C. § 2619 (1988)); Surface Mining Control and Reclamation Act of 1977 (codified at 30 U.S.C. § 1270 (1988)); Clean Water Act of 1976 (codified at 33 U.S.C. § 1365 (1988)); Marine Protection, Research and Sanctuaries Act of 1972 (codified at 33 U.S.C. § 1415(g)(1) (1988)); Safe Drinking Water Act (codified at 42 U.S.C. § 300j-8 (1988)); Noise Control Act of 1972 (codified at 42 U.S.C. § 4911 (1988)); Energy Policy and Conservation Act (codified at 42 U.S.C. § 6305 (1988)); Solid Waste Disposal Act (codified at 42 U.S.C. § 6972 (1988)); Clean Air Act (codified at 42 U.S.C. § 7604 (1988 and Supp. 1990)); Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (codified at 42 U.S.C. § 9659 (1988)); Powerplant and Industrial Fuel Use Act of 1978 (codified at 42 U.S.C. § 8435 (1988)); Emergency Planning and Community Right-to-Know Act of 1986 (codified at 42 U.S.C. § 11046(a)(1) (1988)); Outer Continental Shelf Lands Act (codified at 43 U.S.C. § 1349 (1988)); Hazardous Liquid Pipeline Safety Act of 1979 (codified at 49 U.S.C. § 2014 (1988)).

the late 1990s, the Court issued two rulings that strengthened state sovereign immunity. *Seminole Tribe v. Florida* held that Congress could no longer abrogate state sovereign immunity except through its Fourteenth Amendment enforcement powers.²⁷³ *College Savings Bank v. Florida Prepaid Postsecondary Education Expense Board* found that Congress could not obtain constructive waiver of state sovereign immunity merely by specifying that state actors partaking in regulated activity would be subject to suit in federal court.²⁷⁴ In light of these opinions, states could only be sued by private plaintiffs under *Ex parte Young*—which stipulates that, since the state cannot empower officials to violate federal law, officials who do so are no longer acting for the government.²⁷⁵ To succeed in such a suit, private litigants must identify a particular state official responsible for the violation.²⁷⁶ Subsequent decisions have further complicated this doctrine,²⁷⁷ and after ten years since *Seminole Tribe* and *College Savings*, scholars of cooperative federalism continue to bemoan ever-tightening judicial standards for theories under which private citizens can bring suit against states to enforce these acts.²⁷⁸ Still, provisions which allow individual actors to serve as

273. 517 U.S. 44, 62-65 (1996) (holding that section 5 of the Fourteenth Amendment was created to shift the balance of state and federal powers to promote civil rights, but that other rationales for abrogating the sovereign immunity of the states do not stand up).

274. 527 U.S. 666, 672-74 (1999).

275. See Rispin, *supra* note 76, at 1648-49. *Ex parte Young*, 209 U.S. 123 (1908), applies only to federal law, which has spurred states to claim they cannot be held accountable for enforcing the portion of a cooperative statute that is state law. See *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 106 (1984); see also *Bragg v. W. Va. Coal Ass'n*, 248 F.3d 275, 297-98 (4th Cir. 2001) (holding that a congressional invitation for a state to create its own laws under a federal program makes the state laws exclusive and state officers immune from suit under *Ex parte Young*). Note that private litigants acting under *Ex parte Young* cannot seek damages or retroactive relief. See *Edelman v. Jordan*, 415 U.S. 651, 667-69 (1974) (rejecting an injunction granted in an *Ex parte Young* action ordering payment of previously owed benefits); see also *Quern v. Jordan*, 440 U.S. 332, 337 (1979) (“The distinction between that relief permissible under the doctrine of *Ex parte Young* and that found barred in *Edelman* was the difference between prospective relief . . . and retrospective relief.”).

276. See *Ex parte Young*, 209 U.S. at 149-56; Rispin, *supra* note 76, at 1648-49.

277. See *Idaho v. Coeur d’Alene Tribe of Idaho*, 521 U.S. 261, 269-70 (1997) (creating a balancing test of state and federal interests to determine whether the violation of a cooperative statute is federal and *Ex parte Young* can apply); *Seminole Tribe*, 517 U.S. at 74 (holding that *Ex parte Young* suits should not be entertained where the statute lays out a “detailed remedial scheme” for enforcement).

278. See, e.g., Adam Babich, *The Supremacy Clause, Cooperative Federalism, and the Full Federal Regulatory Purpose*, 64 ADMIN. L. REV. 1, 17-18 (2012); Robert L. Glicksman, *From Cooperative to Inoperative Federalism: The Perverse Mutation of Environmental Law and Policy*, 41 WAKE FOREST L. REV. 719, 764 (2006); Margo Hasselman, *Bragg v. W. Va. Coal Ass’n and the Unfortunate Limitation of Citizen Suits Against the State in Cooperative Federalism Regimes*, 29

“private attorneys general”²⁷⁹ and demand enforcement would be useful additions to the MHPAEA to the extent that current *Ex parte Young* doctrine permits them.

Although private rights of action against states are unlikely to be available in many cases given sovereign immunity’s current, broad scope, the doctrine continues to develop and may be applicable in a subset of cases.²⁸⁰ Insurance providers, however, are private entities and not subject to sovereign immunity. Thus, private rights of action against non-governmental entities may be a feasible option. Currently, those individuals whose plans are covered by ERISA have a private right of action against insurance providers, via ERISA section 502’s civil enforcement procedures.²⁸¹ Future amendments to the MHPAEA should expand private rights of action to all whose insurance is covered by the statute.

Any citizen suit provision would be subject to similar concerns to those levied against existing enforcement structures, which rely heavily on consumer complaints. As described above, state and federal regulators alike have struggled to solicit such complaints and to educate consumers on their rights. Coupled with asymmetric information about internal- and aggregate-insurer practices, much of which is highly technical and complex, the structure of the MHPAEA presupposes vigorous federal enforcement and the overall number of private suits is likely to remain relatively low.

ECOLOGY L.Q. 205, 218–26 (2002); Anuradha Sivaram, *Why Citizen Suits Against States Would Ensure the Legitimacy of Cooperative Federalism Under the Clean Air Act*, 40 ECOLOGY L.Q. 443, 459–60 (2013).

279. Sivaram, *supra* n. 278, at 474.

280. See, e.g., Katherine Florey, *Sovereign Immunity’s Penumbra: Common Law, “Accident,” and Policy in the Development of the Sovereign Immunity Doctrine*, 43 WAKE FOREST L. REV. 765, 765 (2008) (describing sovereign immunity as a judge-made doctrine, identifying the role of lower courts in advancing it, and hailing *Seminole Tribe* and ensuing cases for “reinvigorat[ing]” the doctrine). Note that the Supreme Court has suggested that, in some cases, private actors may be able to challenge affirmative decisions reached by federal agencies pursuant to the MHPAEA under the Administrative Procedure Act (APA), rather than challenging states via the Supremacy Clause. See *Douglas v. Indep. Living Ctr.*, 565 U.S. 606, 614 (2012) (suggesting that healthcare providers seek review of Centers for Medicare & Medicaid Services decisions under the APA rather than via a Supremacy Clause challenge). The federal government could also condition matching funds for targeted grants related to mental-health parity on states waiving sovereign immunity for cases brought under parity laws.

281. See 29 U.S.C. § 1132 (2018); see also *American Psychiatric Ass’n v. Anthem Health Plans*, 50 Supp. 3d 157, 161 (D. Conn. 2014) (noting that “[a]lthough there is no private right of action under the Parity Act, portions of the law are incorporated into ERISA and may be enforced using the civil enforcement procedures in ERISA § 502, to the extent that they apply”).

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Nevertheless, prospective plaintiffs may be incentivized by greater control over the process and the possibility of an individualized remedy. Furthermore, individual private plaintiffs or classes of plaintiffs may reach settlements that include nationwide relief similar to the landmark state settlements above, providing yet another gap-filling enforcement measure and incentive for motivated private litigants.

B. The Path Forward Under the MHPAEA

Descriptive analysis of the MHPAEA's interpretation and enforcement structure, coupled with empirical analysis of its intended outcomes, is a crucial first step in analyzing any cooperative federalist statute. This Section proposes additional reforms, including minimizing reliance on consumer complaints, expanding state enforcement, and increasing consumer education and participation.

1. Encourage Proactive, Coordinated Federal Action

The recent decline in EBSA enforcement is of particular concern because EBSA regulates over 66% of health-insurance plans, covering over one-hundred-million individuals.²⁸² States have no ability to fill this enforcement gap due to ERISA preemption. As the 2018 GAO report noted, both EBSA and CMS enforcement are over-reliant on consumer complaints, which have also decreased in number.²⁸³ Critics of the law suggest that this is a self-reinforcing failure; minimal enforcement provides little clarity regarding the scope of the MHPAEA protections, so consumers do not know what insurer practices violate the law, which means that agencies cannot then pursue settlements.²⁸⁴

The GAO report therefore urges programmatic enforcement that does not rely on consumer complaints.²⁸⁵ This could include quarterly reviews of randomly selected plans and expanded reporting and transparency requirements. Although self-certification of compliance by insurers may be useful in some instances, continued interpretive difficulties limit these compliance tools' usefulness. Moreover, self-certification by insurers cannot replace third-party investigations. Because of its resources and primary authority over the majority of

282. See EMP. BENEFITS SEC. ADMIN., *supra* note 52, at 1.

283. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 44, at 33-36.

284. See Jeremy P. Ard, *An Unfulfilled Promise: Ineffective Enforcement of Mental Health Parity*, 26 ANN. HEALTH L. 70, 78-79 (2017).

285. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 44, at 42-43.

insurance plans, the federal government is better situated than many states to carry out these insurance investigations, which rely on experts to review thousands of documents. Centralizing federal the MHPAEA enforcement and regulation under one jointly staffed entity could also mitigate interpretive difficulties and more efficiently utilize investigatory staff.

2. *Expand State Enforcement*

As highlighted by the settlements discussed above, expanding state enforcement is also a critical gap-filling measure. State enforcement agencies enjoy broader authority than federal agencies through their consumer-protection statutes, and they can levy civil fines and reach sweeping prospective settlements. States can also pass parity requirements that are more specific in language and broader in scope than those of the MHPAEA. However, states vary in willingness to pass these laws and to undertake aggressive enforcement efforts. As illustrated by New York's settlement with Anthem, more assertive states may be able to reach settlements with insurers with nationwide effect, which mitigate the consequences of this variation.²⁸⁶ Expanding targeted grant programs, such as "conditional grants" related to state mental-health parity enforcement, could help to incentivize more aggressive state efforts.²⁸⁷ Scholars have also called on Congress to create ERISA preemption waivers, which would dramatically increase the regulatory power of states over health insurance.²⁸⁸ Such waivers could also be coupled with the MHPAEA innovation waivers, such as those granted under Section 1332 of the ACA, which have been associated with positive state engagement in, and expansion of, federal regulatory regimes.²⁸⁹

286. See *Mental Health Parity*, *supra* note 186, at 5.

287. See Charlton C. Copeland, *Beyond Separation in Federalism Enforcement: Medicaid Expansion, Coercion, and the Norm of Engagement*, 15 U. PA. J. CONST. L. 93, 148-49 (2012). States could also be encouraged to enforce the MHPAEA via conditioning of Medicaid or other existing funds, as the ACA attempted to do, although coercion doctrine is somewhat unclear in the wake of *NFIB v. Sebelius*. See *supra* note 99 and accompanying text. New statutory grants would tend to avoid the appearance of coercion.

288. See, e.g., Devon P. Groves, *ERISA Waivers and States Health Care Reform*, 28 COLUM. J.L. SOC. PROB. 609, 623-48 (1994) (considering the effects of ERISA preemption on state health plans and reviewing various proposals to grant ERISA preemption waivers to states); Elizabeth Y. McCuskey, *ERISA Reform as Health Reform: The Case for an ERISA Preemption Waiver*, 48 J.L. MED. ETHICS 450, 453-56 (2020) (arguing that Congress should implement an ERISA preemption waiver and suggesting ways to accomplish this).

289. See Gluck, *supra* note 33, at 562-63 (noting that waivers encouraged state action transforming Medicaid from a program for the "deserving poor" to a "universal-access philosophy").

In 2016, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a report detailing state best practices.²⁹⁰ The report discusses critical reforms such as requiring ongoing all-carrier market conduct examinations,²⁹¹ providing up-to-date, detailed templates and workbooks regarding NQTLs and QTLs for plans,²⁹² and publishing consumer guides informing buyers of insurer-parity information.²⁹³ It renewed calls for decreased reliance on consumer complaints.²⁹⁴ We echo SAMHSA's proposed reforms and suggest that SAMHSA regularly update this report to incorporate changes in best practices and to reinvigorate efforts.

3. Clarify Regulations, Educate Consumers, and Improve Participation

Both federal and state enforcement data demonstrate the need to further educate the public on the scope of the MHPAEA protections. Impermissible NQTLs account for a large (though declining) proportion of EBSA citations, despite federal efforts to clarify their definitions.²⁹⁵ Expanded enforcement efforts, detailed annual reporting of state and federal enforcement, and transparency requirements related to plan provisions could all help patients and issuers alike identify impermissible NQTLs. Active distribution of NQTL worksheets, such as the “Six Step Parity Compliance Guide for NQTL Requirements” developed by the Kennedy Forum,²⁹⁶ or any of the relevant worksheets developed by states discussed above, could also help reduce NQTL violations.

However, ambiguity in existing provisions is only part of the problem. Some plan non-compliance may be unrelated to interpretive issues, as suggested by the growing number of QTL violations (which are easier to classify than

290. See *Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Aug. 2016), <https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983> [https://perma.cc/WKR8-C2JK].

291. See *id.* at 3, 6.

292. See *id.* at 4-5.

293. See *id.* at 5-6.

294. See, e.g., Megan Douglas et al., *supra* note 137, at 12.

295. See *supra* Table 2.

296. See Tim Clement et al., *The “Six-Step” Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements*, KENNEDY F. (Sept. 2017), <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/faq-38/00018.pdf> [https://perma.cc/J6KA-NQTK].

NQTL violations due to their quantitative nature) reported by EBSA. Public evidentiary hearings and expanded private rights of action would help to clarify outstanding interpretive issues and focus enforcement on problem areas.

4. *Refocus on Outcomes*

Finally, legislators must grapple with the MHPAEA's focus on equality of process rather than equity in outcome. Although the ACA mandated coverage of certain mental-health conditions through its essential-health-benefits requirements, the MHPAEA itself does not require that insurers cover mental-health conditions. To achieve true parity, future legislation must refocus on producing equitable access, quality, and coverage for mental-health and substance-use-disorder treatments. Expanded mandatory assessment and reporting of mental-health and substance-use-disorder coverage and outcomes at the state and federal level would help to refocus reform efforts on outcomes rather than process.

CONCLUSION

The Mental Health Parity and Addiction Equity Act was an historic step in the federal regulation of health insurance, traditionally the domain of the states. By making access to mental-health and substance-abuse treatment a national discussion, the MHPAEA lanced at stigma. Ten years post-enactment, however, millions of Americans still lack parity in insurance coverage, and countless individuals with mental illness go without treatment.

This failure to achieve parity stems in part from the MHPAEA's peculiar cooperative-enforcement structure, which created enforcement gaps, interpretive ambiguity, and widespread confusion among both issuers and consumers regarding the scope of requirements and protections. Still, when the MHPAEA has been enforced successfully, both state and federal governments have returned millions of dollars to consumers, and a few states have reached landmark parity settlements.

To reform the MHPAEA as it exists, a more reflexive and empirical approach to federalism is necessary. Indeed, "cooperative federalism is more nuanced than commonly acknowledged,"²⁹⁷ and state-federal arrangements can be structured in innumerable ways. If sufficiently dynamic, a cooperative arrangement should grow over time, guided by quantitative results and the overarching statutory goals.

297. See Gluck, *supra* note 33, at 534.

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Because the MHPAEA suffers from underenforcement, the law should be amended to align with cooperative statutes like the Telecommunications Act by enhancing private rights of action against both insurers and regulators, increasing and formalizing collaboration between stakeholders and enforcement agencies, and clarifying state and federal roles. In acknowledgment of recent landmark state settlements, the federal government should borrow from the ACA to encourage states to make more thorough use of their unique enforcement abilities via incentives such as conditional grant programs or matching funds to states engaging in aggressive enforcement. The federal government could also require annual reporting by states of the MHPAEA-related enforcement data, allowing more insight into best practices and persistent enforcement gaps. Finally, both state and federal agencies should take a proactive approach; rather than responding to consumer complaints, they must educate consumers on what to expect and issuers on what to provide, while conducting regular audits not triggered by consumers.

We have seen that cooperative federalism is only as strong as its mechanisms permitting such cooperation, such as private rights of action or the use of boards. If reforms cannot succeed in streamlining cooperation, legislators might consider simply adopting a dual-enforcement approach, tasking the federal government with regulating only where states are preempted from doing so. Alternatively, reform might further centralize regulation of health insurance at the federal level to achieve the goal of comprehensive, uniform equality in mental-health and substance-abuse coverage. Along with such reform must come simplified federal interpretive and enforcement authority, although defragmentation of the American health-care system would be a major undertaking. Health-care centralization would also have to avoid the unconscious preemption typified by ERISA, and the bounds of unconstitutional coercion implicated by the ACA. Under either approach, legislators should ground statutory revision in empirical analysis, and, crucially, must focus not just on parity in process, but rather parity in outcomes.