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Mental Health Parity and LGBTQ Health

Access to behavioral health treatment is especially critical for LGBTQ people, who are more than twice as likely as heterosexuals to experience a mental health condition, according to the National Alliance for Mental Illness. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("the Parity Act") requires the vast majority of public and private health insurance plans to provide behavioral health benefits in parity with medical and surgical benefits. Put simply, the law requires health insurers to treat mental illness like they would a broken bone. The Parity Act and its implementing regulations establish standards and guidance for mental health care coverage, but for some, coverage for mental health treatment remains elusive.

This presentation will provide an overview of the Parity Act and its applicability to various types of health insurance plans, discuss the legal framework used to determine whether an insurer is providing mental health benefits in parity, outline the law's enforcement mechanisms, and highlight recent Parity Act court cases. For beneficiaries of most employer-sponsored health plans, the Parity Act may be privately enforced through the Employee Retirement Income Security Act of 1974 (ERISA). Since the passage of the Parity Act in 2008, regulators and advocates have expressed concerns about compliance with the law. The presentation will highlight perspectives from LGBTQ advocates to foster discussion about how the promise of mental health parity may yet be achieved. This session will focus on information likely to be useful for attorneys representing patients, providers, insurers, employers, and LGBTQ advocates.

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Mental Health Parity and LGBTQ Health
Presentation Outline
By: Derek C. Waller

I. Mental Health Care and LGBTQ Communities
   a. Increased risk across the LGBTQ communities, especially where individuals have multiple minority identities:
      i. Increased risk for behavioral health conditions[2]
      ii. Increased risk for LGBTQ BIPOC individuals[3]
      iii. Increased risk for individuals living with HIV[4]
      iv. Increased risk for youth[5]
         1. According to the 2022 Trevor Project survey of LGBTQ youth, "60% of LGBTQ youth who wanted mental health care in 2021 were not able to get it."[6]
         2. 41% of those who wanted mental health care but were unable to get it cited lack of affordability as a reason.[7]
         3. "LGBTQ college students with access to mental health services through their college had 84% lower odds of attempting suicide in the past year compared to LGBTQ college students without access."[8]
   b. Minority Stress Theory[9]
      i. Minorities face greater stigmatization, discrimination, and fear of rejection based on their identities.
      ii. This is especially true for groups with intersectional minority identities (*e.g.*, queer black women, non-binary Latinx people, transgender Asian men).

II. Mental Health Parity in Federal Law
   a. What is Mental Health Parity?
      i. "The Parity Act promotes equal access to treatment for [mental health and substance use disorders] (SUDs) by prohibiting coverage limitations that

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[2] Grace Medley et al., *Sexual Orientation and Estimates of Adult Substance Use and Mental Health: Results from the 2015 National Survey on Drug Use and Health*, NAT'L SURV. ON DRUG USE & HEALTH DATA REV. (Oct. 2016), https://www.samhsa.gov/data/sites/default/files/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015/NSDUH-SexualOrientation-2015.htm.
[3] Vivek Datta, Philip A. Bialer, & Christopher A. McIntosh, *Queerly Invisible: LGBTQ People of Color and Mental Health*, 21 J. GAY & LESBIAN MENTAL HEALTH 191, 191-93 (2017) https://www.tandfonline.com/doi/full/10.1080/19359705.2017.1320889.
[4] *HIV and AIDS and Mental Health*, NAT'L INST. MENTAL HEALTH, https://www.nimh.nih.gov/health/topics/hiv-aids.
[5] *2022 National Survey on LGBTQ Youth Mental Health*, TREVOR PROJECT, https://www.thetrevorproject.org/survey-2022/.
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *See* Asleigh J. Rich et al., *Sexual Minority Stress Theory: Remembering and Honoring the Work of Virginia Brooks*, 7 LGBT HEALTH 124 (2020), https://www.liebertpub.com/doi/10.1089/lgbt.2019.0223.

apply more restrictively to [mental health and SUD] benefits than for medical/surgical benefits."[10]

ii. This means that any limitations placed on mental health benefits cannot be less favorable than any equivalent limitations placed on medical/surgical benefits.

iii. In plain language, the law requires applicable insurers to "treat sicknesses of the mind in the same way that they would a broken bone." *L.P. ex rel. J.P. v. BCBSM, Inc.*, No. 18-cv-1241 (MTD/DTS), 2020 WL 981186, at *5 (D. Minn. Jan. 17, 2020).

b. Origins and History

i. The Mental Health Parity Act of 1996 provided that group health plans could not impose annual or lifetime limits on mental health benefits that were less than limits imposed on medical/surgical benefits.

ii. Sponsored by Senators Paul Wellstone (D-MN) and Pete Domenici (R-NM).

c. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act")

i. Filled in many gaps in the 1996 Parity Act by applying to all large group plans and requiring parity in treatment limitations, cost-sharing, and other categories.

ii. Spearheaded by Representatives Jim Ramstad (R-MN) and Patrick Kennedy (D-RI).[11]

iii. Extends parity protections to substance use disorder ("SUD") coverage, which was not included in the 1996 law.

d. Patient Protection and Affordable Care Act ("ACA")

i. Expanded substantive requirements for health plans.

ii. Requires coverage of essential health benefits for qualified health plans (required to be sold on the health insurance exchanges). 42 U.S.C. § 18022(b).

iii. Requires coverage of preventive health services without cost-sharing (e.g., co-pays, deductibles). 42 U.S.C. § 300gg-13.

iv. Prohibition on preexisting condition exclusions and discrimination based on heath status. 42 U.S.C. §§ 300gg-3, 300gg-4. This was significant for mental health and SUD treatment, as those conditions are often a "preexisting condition."

v. Prohibition on annual or lifetime limits. 42 U.S.C. § 300gg-11.

vi. To the extent the ACA increased coverage requirements for medical/surgical benefits, plans covered by the Parity Act were required to increase coverage for mental health or substance use benefits.

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[10] U.S. Dep't Lab., U.S. Dep't Health & Hum. Servs, & U.S. Dep't Treasury, *2022 MPHAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage* 7, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[11] *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, 404-43 (2010) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2950754/ (chronicling the political history of efforts to enact the Parity Act).

III. Applicability of the Parity Act

a. Government Insurance Plans

i. Medicaid Plans

1. Includes managed Medicaid and Children's Health Insurance Program ("CHIP") plans. 42 C.F.R. § 440.395.

ii. Medicare Plans

1. Parity *does not apply* to traditional Medicare or Medicare Advantage plans.[12]

iii. Government Employee Plans

1. Includes the Federal Employee Health Program[13]
2. Includes *some* state and local employee plans, but self-insured non-federal governmental plans may opt out.[14]

b. Private Employer-Sponsored Plans

i. Includes grandfathered plans.[15]

ii. Small employers (50 or fewer employees) technically exempt, 29 U.S.C. § 1185a(c)(1), *but* all non-grandfathered small-group market plans must provide essential health benefits, including mental health and SUD benefits, and those benefits must comply with the Parity Act.[16] Effectively, this means the Parity Act usually applies to small-employer plans.

c. Individual and Small Group Market Plans

i. Includes all plans sold on the ACA exchanges and small-employer plans.

d. Exceptions

i. Retiree plans. 29 U.S.C. § 1191a(a).

ii. Excepted benefits. 29 U.S.C. § 1191a(b). For example, accidental death and dismemberment insurance, auto insurance, travel insurance, liability insurance. 45 C.F.R. § 148.220.

e. Minnesota Parity Act

i. Many states have enacted their own version of the Parity Act, including Minnesota. *See* Minn. Stat. § 62Q.47.

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[12] The Senate Finance Committee is currently considering legislation to address this issue: MENTAL HEALTH PARITY IMPROVEMENTS ACT, KEL22782 CX4 (Discussion Draft) https://www.finance.senate.gov/imo/media/doc/120122%20Finance%20Committee%20Mental%20Health%20Parity%20Discussion%20Draft.pdf.

[13] Kay T. Ely, *Letter No. 2008-17: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 – Federal Employees Health Benefits Program Carrier Guidance*, U.S. OFF. PERS. MGMT INS. PROGRAM SERVS (Nov. 10, 2008), https://www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf.

[14] Steve Larsen, *Amendments to the HIPAA Opt-Out Provision (Formerly Section 2721(b)(2) of the Public Health Service Act) Made by the Affordable Care Act*, U.S. DEP'T HEALTH & HUM. SERVS (Sept. 21, 2010), https://www.cms.gov/CCIIO/Resources/Files/Downloads/opt_out_memo.pdf.

[15] *See Affordable Care Act Implementation FAQs – Set 17*, CTRS MEDICARE & MEDICAID SERVS, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs17. Grandfathered plans are plans that were in effect on March 23, 2010 and have maintained its status as a grandfathered plan consistent with federal regulations. *See* 29 C.F.R. § 2590.715-1251. These plans are not subject to certain ACA requirements and must notify all members of the plan's grandfathered status to maintain that status. Practice tip: just because a plan purports to be grandfathered, it does not mean the plan has satisfied the necessary criteria.

[16] *Affordable Care Act Implementation FAQs – Set 17*, CTRS MEDICARE & MEDICAID SERVS, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs17.

ii. Coverage for some types of plans as defined in Minn. Stat. § 62A.011. Does not cover liability insurance, long-term care policies, Medicare supplements, workers' compensation, or the medical component of no-fault auto insurance.

IV. Standard for Measuring Parity

a. Types of Treatment Limitations

i. Quantitative Treatment Limitations (QTLs)

1. Any limitations on benefits "based on the frequency of treatment, number of visits, days of coverage, days in a waiting period." 29 C.F.R. § 2590.712(a).
2. If it is expressed numerically and limits treatment, it is a quantitative limitation.

ii. Non-quantitative Treatment Limitations (NQTLs)

1. Anything that limits the scope or duration of benefits for treatment in a non-quantitative manner, including "as written and in operation, any processes, strategies, evidentiary standards." 29 C.F.R. § 2590.712(c)(4)(i).
2. Examples include medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness; formulary design for prescription drugs; standards for provider admission to participate in a network, including reimbursement rates; restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services. 29 C.F.R. § 2590.712(c)(4)(ii).
3. Note: Medical necessity criteria must be made available to a plan participant upon request. 29 C.F.R. § 2590.712(d)(1).

b. How Parity is Measured

i. In general, parity requires that any financial requirement or treatment limitation for mental health or SUD treatment is not more restrictive than the predominant requirement or limitation applied to medical/surgical benefits in the same "classification." 29 C.F.R. § 2590.712(c)(2)(i).

ii. The Parity Act regulations establish "classifications" in which to measure parity, 29 C.F.R. § 2590.712(c)(2)(ii)(A):

1. Inpatient, in-network
2. Inpatient, out-of-network
3. Outpatient, in-network
4. Outpatient, out-of-network
5. Emergency care
6. Prescription drugs

iii. The preamble to the Parity Act final rule states, as examples:

1. "if a plan or insurer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment

facilities for mental health or substance user disorders as an inpatient benefit." 78 Fed. Reg. at 68,247

2. "[I]f a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well." 78 Fed. Reg. at 68,247

c. Common Examples of Noncompliance[17]

i. Blanket exclusions
   1. All residential mental health treatment for adults is excluded.
   2. All residential SUD treatment for adults is excluded.

ii. Prior authorization requirements without comparable restriction in medical/surgical context
   1. Blanket preauth requirements (e.g., preauthorization is required for *all* mental health and SUD services).
   2. Requiring prior authorization before admission to a facility for mental health or SUD treatment, or else
   3. Requires medical necessity review by its own providers, whereas it defers medical necessity review to attending physician for medical services.

iii. Fail first protocols
   1. Requires a showing that member first try outpatient treatment for SUD before inpatient treatment.
   2. Requires that a patient first complete a partial hospitalization (intensive outpatient) treatment program before a residential or inpatient program.

iv. Probability of improvement
   1. For residential treatment, requires proof of a likelihood of improvement as a result of inpatient treatment.
   2. Only covers services that result in measurable and substantial improvement within 90 days.

v. Written treatment plans
   1. Requires provider to create a written treatment plan prescribed and supervised by a behavioral health provider.
   2. Requires individualized treatment plan within 7 days and requires plan review once a week for progress.
   3. Requires plan submission on a regular basis.

vi. Patient non-compliance
   1. Excludes services if patient fails to comply with the treatment plan, and/or excluding benefits if patient ends treatment against medical advice.
   2. Imposes specific licensure requirements for the mental health or SUD facility, but does not impose the same requirements on the comparable medical surgical facility.

[17] *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*, U.S. DEP'T LAB. & U.S. DEP'T HEALTH & HUM. SERVS, https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/mhapeachecklistwarningsigns.pdf.

V. Parity Act Enforcement

a. Government Enforcement

i. Enforcement varies based on the type of plan, but generally falls to either the Department of Labor (for employer-sponsored plans) or Health and Human Services (for public plans).

ii. The Consolidated Appropriations Act of 2021 amended the Parity Act to require insurers to "perform and document comparative analyses of the design and application of NQTLs, beginning 45 days after December 27, 2020." 29 U.S.C. § 1185a(a)(8)(A).

iii. Recent research into Parity Act compliance suggests significant compliance issues:[18]

1. EBSA issued 156 letters to plans requesting comparative analyses for 216 NQTLs across 86 investigations.
2. CMS issued 15 letters.
3. *None* of the comparative analyses received were sufficient upon initial receipt—that is, **100% resulted in an initial determination of non-compliance with the Parity Act.**
4. EBSA issued 80 insufficiency letters,
5. CMS issued 19 insufficiency letters.
6. Enforcement efforts ongoing as of October 31, 2021 (date report was starting to be compiled).

b. Private Civil Enforcement

i. The Parity Act can be enforced against employer-sponsored plans in federal court using the cause of action established by the Employee Retirement Income Security Act of 1974 ("ERISA"). *See* 29 U.S.C. 1132.

ii. The Parity Act is incorporated into ERISA and therefore enforceable through 29 U.S.C. § 1132 as a substantive requirement of ERISA. 29 U.S.C. § 1185a.

iii. Mandatory administrative exhaustion requirements before filing in court.

iv. Remedies generally limited to the benefits owed under the plan.

v. Unlike most ERISA benefits litigation, a more favorable *de novo* standard of review applies to Parity Act issues because liability turns on the interpretation of the Parity Act and its regulations. *See L.P. ex rel. J.P. v. BCBSM, Inc.*, No. 18-cv-1241 (MTD/DTS), 2020 WL 981186, at *4 (D. Minn. Jan. 17, 2020).

vi. Terms of the specific plan control but cannot conflict with federal law.

VI. Specific Coverage Issues

i. Gender-affirming behavioral health care

1. *Duncan v. Jack Henry & Assocs., Inc.*, -- F. Supp. 3d ---, 2022 WL 2975072, 2022 U.S. Dist. LEXIS 132980 (W.D. Mo. July 27, 2022).
2. The plaintiff was a transgender woman who was diagnosed with gender dysphoria and sought facial gender confirmation surgery.

[18] 2022 MPHAEA Report to Congress *supra* note 10.

3. The plan excluded all cosmetic surgery, whether or not for psychological reasons, but covered reconstructive surgery *if* it was used to "achieve a normal or nearly normal appearance" as a result of a illness or accident.
4. Under Rule 12, the Court held this stated a claim for a Parity Act violation.

ii. Substance Use Treatment
   1. LGBTQ individuals are more likely to suffer from a SUD.[19]

iii. Eating disorder treatment
   1. LGBTQ youth experience significantly higher rates of eating disorders than their heterosexual and cisgender peers.[20]
   2. *Stone v. UnitedHealthcare Ins. Co.*, 979 F.3d 770 (9th Cir. 2020).
      a. Court held that geographic limitation on all out-of-state care that applied equally to medical and mental health services was not a violation of the federal Parity Act.

Additional Parity Act Resources:

- U.S. Department of Labor: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
- National Alliance on Mental Illness (NAMI): https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Parity
- The Kennedy Forum: https://www.thekennedyforum.org/vision/parity/

Professional Resources:

- Minnesota Disability Bar Association: https://www.mdisba.org/
- Lawyers Concerned for Lawyers: https://www.mnlcl.org/
- Substance Abuse and Mental Health Services Administration (SAMHSA): https://www.samhsa.gov/

[19] *Substance Use and SUDs in LGBTQ* Populations*, NAT'L INSTS HEALTH, https://nida.nih.gov/research-topics/substance-use-suds-in-lgbtq-populations.

[20] *Eating Disorders Among LGBTQ Youth*, TREVOR PROJECT (Feb. 17, 2022), https://www.thetrevorproject.org/research-briefs/eating-disorders-among-lgbtq-youth-feb-2022/.