

Potential Federal Reforms to Advance the Federal Parity Act & End Wrongful Coverage Denials of Mental Health Addiction Care

- 1. Require Transparent Health Plan Data Reporting:** As the Milliman data makes clear, deep inequities in mental health and addiction coverage persist. All insurers and plan third-party administrators should be required to report claims data on areas such as mental health/addiction and medical/surgical denial rates, utilization review practices, appeals, out-of-network usage, and reimbursement. Without such transparency, we will be unable to measure progress. New York State recently [enacted](#) such reporting requirements, and there are efforts such as the Mental Health Treatment and Research Institute's [Model Data Request Form](#), which shows how to collect critical data.
- 2. Give USDOL the Power to Fine Plans for Parity Violations:** Currently, the U.S. Department of Labor lacks civil monetary penalty authority to punish parity violations, leaving USDOL without a critical stick to change insurer practices. Congress must pass [H.R. 2848](#) immediately to give USDOL this critical power. This was a key [recommendation](#) of President Trump's Commission on Combating Drug Addiction and the Opioid Crisis, on which former Congress Patrick J. Kennedy served.
- 3. Allow USDOL to Charge Plans for Cost of Parity Investigations:** Currently, USDOL does not have the resources necessary to ensure that all health plans under its jurisdiction are parity compliant, having only one investigator for every [10,000 plans](#). USDOL should be given the same authority as many state insurance departments have: The power to charge plans for the cost of investigations. Such power has been critical to holding insurers accountable in states like Pennsylvania.¹
- 4. Create Definition of Medical Necessity & Identify Compliant Medical Necessity Criteria:** As shown by a recent landmark federal class-action ruling ([Wit v. United Behavioral Health](#)), insurers are not required to use medical necessity criteria that comply with generally accepted standards of behavioral health care or that are externally validated. To fix the endemic use of flawed medical necessity criteria that improperly restrict coverage for medically necessary mental health and addiction services, Congress should require that all health plans base coverage determinations on generally accepted standards of care and should mandate the use of medical necessity criteria developed by non-profit clinical specialty associations such as The ASAM Criteria and the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS).
- 5. Expand Minimum Coverage Requirements for MH/SUD Intermediate Services:** The Milliman report shows that more than 50 percent of coverage for residential treatment centers occurs out-of-network – or nearly 16 times higher than inpatient out-of-network utilization for medical/surgical inpatient care. Insurers continue to deny and exclude

¹ See provisions in [40 P.S. Insurance § 323.4](#) and [40 P.S. Insurance § 323.7](#).

intermediate levels of care for mental health and addiction treatment. Congress should make clear that insurers must cover the full range of levels of care described by non-profit clinical specialty associations.

6. **Ensure Private Right of Action for Parity with the Ability to Recover Damages:** When insurers deny coverage for needed care, patients frequently lack meaningful remedies to get the coverage they need. Although ERISA provides for a private right of action to enforce the Federal Parity Act, the Public Health Services Act does not, leaving tens of millions of Americans without a private of right of action to protect their right to equitable coverage. Furthermore, federal law does not currently give individuals who have been wrongly denied coverage for mental health or addiction care and have been harmed as a result the right to recover damages. Without private enforcement of the Parity Act that compensates for the harm illegal coverage denials cause, people’s rights will continue to hinge on inadequate state and federal regulator activities that fail to uncover or correct many violations.
7. **Prohibit “Discretionary” Clauses Under ERISA:** The [National Association of Insurance Commissioners](#) has recommended that states prohibit “discretionary” clauses in insurance policies. If allowed, these clauses give insurers the right to interpret the meaning of their own policies. Half of states have outlawed such provisions. However, the U.S. Supreme Court in a 1989 decision, *Firestone Tire and Rubber Co. v. Bruch*, interpreted ERISA as requiring federal courts to give deference to health plans’ interpretations of their policies if they contained “discretionary” clauses. Not surprisingly, such clauses have proliferated. Congress should make these “discretionary” clauses unenforceable since health plans that abuse their discretion then enjoy the benefit of deferential judicial review.