Introduction

Substance use disorders are pervasive. In 2012, twenty-two million Americans...
were classified with alcohol or substance abuse and it is estimated that by 2020
substance use disorders will surpass all physical diseases as a major cause of disability
worldwide.\textsuperscript{2} The problem is not exclusively individual; the annual total estimated
societal cost of substance use disorders in the United States is $510.8 billion, as it is
correlates with criminal behavior, low education, and high unemployment.\textsuperscript{3}

Two primary reasons Americans cite for not receiving necessary substance use
disorder treatment are lack of insurance coverage and insurance coverage that does not
cover the entire treatment or cost.\textsuperscript{4} To remedy this situation, in recent years federal
lawmakers have made great efforts with respect to substance use disorder benefit parity,
which refers to the provision of substance use disorder insurance coverage that is at least
equal, in terms of financial requirements and treatment limitations, to coverage offered
for physical health benefits.\textsuperscript{5} However, notwithstanding such efforts, many Americans

\begin{footnotesize}
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\item See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2012 NAT'L
SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NAT'L FINDINGS 75 (2013) (“SAMHSA
2012”); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., LEADING CHANGE: A PLAN
as dependent on or abusing alcohol and specific substances is based on criteria specified in DSM-
IV. SAMHSA 2012, supra.
\item See supra note 2; SAMHSA 2012, supra note 2, at 82.
\item SAMHSA 2012, supra note 2, at 88-89. Based on 2009-2012 combined date, 38.2\% of
respondents cited lack of health insurance and inability to afford cost as the primary reason for
not receiving treatment, and 10.1\% replied that they had health insurance but that such insurance
did not cover treatment or cost. Id.
\item See infra Parts I-II (detailing history of substance use disorder parity effort in United States).
See also Mental Health Insurance Under the Federal Parity Law, AM. PSYCHOL. ASS’N (Oct. 2010),
http://www.apapracticecentral.org/good-practice/winter11-mhpaea.pdf (defining substance use
disorder parity); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity
disorder benefits from medical/surgical, i.e. physical, health benefits). Financial requirements
include lifetime and annual dollar limits paid by the insurance plan, and cost-sharing features such as
deductibles, copayments, co-insurance and maximum out-of-pocket reimbursements. See id.
\item Substance-Related and Addictive Disorders, supra. Substances discussed in DSM-V include: alcohol,
amphetamine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidine (PCP),
and sedatives, hypnotics or anxiolytics. See DSM-IV, supra, at 175; Substance-Related and Addictive
Disorders, supra. Although each specific substance is addressed as a separate use disorder,
diagnosis for almost all is based on the same criteria. See Substance-Related and Addictive Disorders,
supra.
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continue to confront barriers to substance use disorder health care coverage and treatment that they do not face with respect to other types of physical illnesses.6

This note outlines the history of substance use disorder health insurance benefits in the United States, illustrating legislative efforts aimed at parity in availability and cost of care. Part I of the note describes early federal efforts made at substance use disorder parity. Parts II and III then focus on the changes made to substance use disorder benefits under the Patient Protection and Affordable Care Act ("ACA"), and question whether such efforts are enough to establish parity between substance use disorder benefits and all other physical health benefits in employer-sponsored and individually purchased health plans. Finally, the note concludes that although the ACA expands parity of substance use disorder benefits in the private insurance market, exemptions in this health care law leave many individuals and employers free to evade federal parity requirements. Further governmental efforts must be made and loopholes closed if full parity of substance use disorder health coverage is to be attained.

I. History

A. The Federal Push for Parity

The federal effort for benefit parity began in the United States in the 1990s.7 The effort came as a response to the restrictive mental health and substance use disorder benefits offered during the 1970s and 1980s.8 Widespread limitations and exclusions on

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6 See infra notes 18-20, 29 and accompanying text (describing substance use disorder treatment barriers and number of Americans facing such barriers).

7 See H.R. REP. NO. 110-374, pt. 1, at 1505 (2007). Senators Pete Domenici and John Danforth introduced the first mental health parity act, the Equitable Health Care for Severe Mental Illnesses Act, on May 12, 1992 during the 102nd Congress. Id.; S. 2696, 102nd Cong. (1992). The bill proposed “[t]o establish a comprehensive policy with respect to the provision of health care coverage and services to individuals with severe mental illnesses . . .” Id. However, the bill was not passed into law. H.R. REP. NO. 110-374, pt. 1, at 1505.

8 See Michael Carter & Robert Landau, Employers Face Challenges with New Mental Health Parity Act, 41 COMPENSATION & BENEFITS REV. 39, 40 (2009), available at http://cbr.sagepub.com/content/41/1/39. (explaining parity legislation sought to remedy healthcare discrimination of mental illness and substance use disorders). See also PATRICK J. KENNEDY & JIM RAMSTAD, ENDING INSURANCE DISCRIMINATION: FAIRNESS AND EQUALITY FOR AMERICANS WITH MENTAL HEALTH AND ADDICTIVE DISORDERS 6, 11-15 (2007) ("KENNEDY & RAMSTAD") (documenting real-life consequences of restrictive mental health and substance use disorder coverage). In Congressional field hearings, members of Congress heard testimony of families' feelings of betrayal and hopelessness upon learning their high premium insurance was “hollow” when needed for mental health or substance use disorder care; of feelings of confusion and frustration in attempting to stay within cheaper "phantom" provider networks lacking sufficient mental health and substance use disorder professionals, or seek more expensive out-of-network
such coverage during these years were the product of insurers' fear that full mental health and substance use disorder coverage would result in increased utilization of services and therefore higher costs. To protect themselves from financial risk, coverage issuers imposed dollar and visit limits on these services and integrated cost sharing features into their mental and behavioral health policies that were disparate from the benefits offered for physical health.

9 See Paul Fronstin, Issues in Mental Health Care Benefits: The Costs of Mental Health Parity, EMP. BENEFIT RES. INST. 4 (Feb. 1997), http://www.ebri.org/pdf/briefspdf/0297ib.pdf (citing financial concerns as reason for unequal mental health coverage in 1970s and 1980s). Insurers adopted cost-containment measures to deal with two economic concerns — moral hazard and adverse selection. See A REPORT OF THE SURGEON GENERAL, supra note 5, at 420. Moral hazard refers to the situation where people use more services when they have full insurance since they do not bear the full cost of their care. See id. Adverse selection is the tendency of plans with comprehensive coverage to attract individuals with the greatest need for care. See id. A series of studies published in the 1980s on the price elasticity of demand for mental health and substance abuse services substantiated the concerns of insurance providers. See Colleen L. Barry et al., The Costs of Mental Health Parity: Still an Impediment?, 25 HEALTH AFF. 623, 625-27 (2006). Five separate studies reported that price elasticity was higher for mental health and substance addiction care than for general physical health care. See id. at 626-27. Thus, demand for these services decreased as the price to the consumer for such services increased and at a rate greater than that for physical health services. See id. Of the five studies, the RAND Health Insurance Experiment, using randomly assigned subjects, provided the most conclusive evidence that more generous mental health and substance abuse coverage would increase demand, and therefore claims and premium cost. See id.; Willard G. Manning et al., Effects of Mental Health Insurance: Evidence from the Health Insurance Experiment, RAND CORP. 4, 30-31 (1989), http://www.rand.org/content/dam/rand/rand/pubs/reports/2008/R3815.pdf. Similarly, with respect to benefits available prior to 1992, Congress found: only 21% of health insurance programs had inpatient coverage for mental illnesses comparable to coverage for physical illnesses, and only 2% provided comparable outpatient coverage; only 2% of private insurance policies offered adequate mental health coverage; and more than 60% of health maintenance and preferred provider organizations explicitly excluded treatment for severe mental illness. S. 2696, 102d Cong. § 2 (1992). Data from the U.S. Bureau of Labor Statistics also reveals the increase in restrictions beginning in the 1980s. BUREAU OF LABOR STATISTICS, U.S. DEPT' Labor, BULLETIN NO. 2140, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN MEDIUM AND LARGE SIZE FIRMS, 1981 (1982), available at http://www.bls.gov/nec/ecs/sp/ebbl0038.pdf ("BLS 1981"); BUREAU OF LABOR STATISTICS, U.S. DEPT' Labor, BULLETIN NO. 2496, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN MEDIUM AND LARGE PRIVATE ESTABLISHMENTS, 1995 (1998), available at http://www.bls.gov/nec/ecs/sp/ebbl0015.pdf ("BLS 1998").
By the mid-1990s, research revealing the biological bases of mental and behavioral illnesses resulted in increased diagnoses and the advancement of more effective treatment options. Stigmatization slowly subsided, and public opposition to unequal coverage of mental health and substance use disorders grew substantially. Moreover, new studies emerged contending that mental health and substance use benefit parity was not as costly as previously maintained.

For example, in 1981, 41% of privately insured full-time employees faced limits on inpatient mental health care, and 83% were subject to limits on outpatient mental care. BLS 1981, supra, at 6, 27 tbl.26. By 1995, these numbers increased to 81% and 96% respectively. BLS 1995, supra, at 41-42 tbl.76. With regard to substance use treatment specifically, in 1995, 71% of this population was subject to limits on inpatient alcohol detoxification, 70% was subject to limits on inpatient drug detox, 92% faced limits on inpatient substance use rehabilitation, and 93% faced limits on outpatient substance use rehabilitation. Id. at tbls.81-82.

See J. Madeleine Nash, Addicted: Why Do People Get Hooked? Mounting Evidence Points to a Powerful Brain Chemical Called Dopamine, TIME MAGAZINE (May 1997) available at http://content.time.com/time/magazine/article/0,9171,986282,00.html. Stigma in the context of substance use disorders refers to a moralistic view of addiction under which substance users are viewed as “immoral, weak-willed, or as having a character defect requiring punishment or incarceration.” COMMITTEE TO IDENTIFY STRATEGIES TO RAISE THE PROFILE OF SUBSTANCE ABUSE AND ALCOHOLISM, INSTITUTE OF MEDICINE, DISPELLING THE MYTHS ABOUT ADDICTION: STRATEGIES TO INCREASE UNDERSTANDING AND STRENGTHEN RESEARCH 139 (1997). Promotion of oversimplified stereotypes of substance users as untreatable or undeserving of public support leads to underfunding of insurance coverage and treatment programs, and also prevents individuals suffering from substance use disorders from pursuing the treatment they need. Id. at 140. In the early-1990s, “Americans tend[ed] to think of drug addiction as a failure of character. But this stereotype . . . began[ed] to give way to the recognition that drug dependence has a clear biological basis.” Nash, supra, at 70. In 1992, President Clinton and Vice President Gore were among the 535,000 people who signed petitions demanding that health insurance carriers provide coverage for mental health and substance use disorder equal to that provided for physical illnesses. See Clinton, Gore Sign Petitions Supporting Mental Health Coverage With AM-Health Price-Controls, ASSOCIATED PRESS (Mar. 30, 1993) http://www.apnewsarchive.com/1993/Clinton-Gore-Sign-Petitions-Supporting-Mental-Health-Coverage-With-AM-Health-Price-Controls/id-d7946a82b126714856b17e42e8672b.

See Roland Sturm, Effects of Substance Abuse Parity in Private Insurance Plans Under Managed Care, Testimony Presented to the U.S. House of Representatives Subcommittee on Criminal Justice, Drug Policy and Human Resources, RAND HEALTH (Oct. 21, 1999), available at http://www.rand.org/content/dam/rand/pubs/testimonies/2005/CT163.pdf (“Sturm 1999”); Roland Sturm, The Costs of Covering Mental Health and Substance Abuse Care at the Same Level as Medical Care in Private Insurance Plans, Testimony Presented to the Health Insurance Committee, National Conference of Insurance Legislators, RAND HEALTH (July 13, 2001), available at http://www.rand.org/content/dam/rand/pubs/testimonies/2005/CT180.pdf (“Sturm 2001”). In a study on the use and costs of substance use treatment in twenty-five managed care plans that offered “parity level” benefits to enrollees in thirty-eight states, researchers found that providing unlimited mental health and substance use disorder benefits in these plans cost employers roughly $45 per plan member per year in

1995”).
In 1996, as a result of these developments, and after several failed attempts at federal parity legislation, President Bill Clinton signed the Mental Health Parity Act ("MHPA") into law.\textsuperscript{14} Under the MHPA, if a group health plan with more than fifty employees provided mental health coverage, parity between mental health benefits and all other physical health benefits was required with respect to lifetime and annual dollar limits.\textsuperscript{15} Among other shortcomings, the MHPA did not cover treatment for substance use disorders.\textsuperscript{16} Thus, while instrumental in placing benefit parity on the federal agenda, the law proved extremely limited in its actual applicability.\textsuperscript{17}


\textsuperscript{16} See 42 U.S.C. § 300gg-5 (2006); 29 U.S.C. § 1185a (2006) (including no provision for substance use disorder coverage). Other limitations of the MHPA included: (1) it did not mandate that group health plans offer mental health benefits, but merely restricted those plans with mental health coverage from implementing unequal dollar limits; (2) it did not prevent insurers from imposing restrictive service limits on inpatient and outpatient visits or from incorporating excessive cost-sharing provisions in the form of deductibles and coinsurance on mental health services; (3) the parity requirements did not apply to group health plans offered by small employers or to those sold in the individual market; and (4) group plans that would experience more than a one percent increase in claims costs as a result of compliance were exempt. See id. U.S. GEN. ACCOUNTING OFFICE, supra note 10, at 8; The Mental Health Parity Act of 1996, supra note 15. "Small employer" meant those companies that employed two to fifty employees on business days during the preceding calendar year and at least two employees on the first day of the plan year. H.R. REP. NO. 110-374 pt. 2, at 1550 (2008). "Individual" referred to the non-group market. Id.

\textsuperscript{17} Compare Mari C. Kjorstad, The Current and Future State of Mental Health Insurance Parity Legislation, 27 PSYCH. REHAB. J. 34, 36 (2003) (noting "MHPA was . . . major first step for equitable mental
B. Mental Health Parity and Addiction Equity Act

Even though the majority of insurers complied with the MHPA following its enactment, because of the law’s narrow scope, which merely required parity in dollar limits for mental health benefits, many Americans continued to experience difficulty accessing care in the late 1990s.18 In particular, the plight of individuals seeking substance use disorder care magnified, as the new law lacked a provision for substance use disorder parity; substance use disorder coverage continued to incorporate high cost sharing, limits on services, and monetary caps, and many insurers excluded substance use disorder benefits altogether.19 At the turn of the century, of the sixteen million insured Americans addicted to drugs or alcohol, only two percent had access to necessary and effective care.20

Discontented parity advocates called for further action and committed themselves to more comprehensive coverage for a broader population.21 Alongside

health[care] . . . provided . . . blueprint for more comprehensive . . . laws”), with Colleen L. Barry et al., A Political History of Federal Mental Health and Addiction Insurance Parity, 88 MILBANK Q. 404, 409 (2010) (referring to 1996 Act as “scaled-back” and noting its shortcomings), and Daniel P. Gitterman et al., Toward Full Mental Health Parity And Beyond, 20 HEALTH AFF. 68, 69 (2001) (arguing “[f]ull parity . . . is unlikely to happen unless the 1996 MPH A is amended”). See Dana L. Kaplan, Can Legislation Alone Solve America’s Mental Health Dilemma? Current State Legislative Scheme Cannot Achieve Mental Health Parity, 8 QUINNIPAC HEALTH L. J. 325, 330 (2005) (attributing limited scope of final legislation to need to satisfy opposition groups in Congress); Carolyn M. Levinson & Benjamin G. Druss, The Evolution of Mental Health Parity in American Politics, 28 ADMIN. & POL’Y IN MENTAL HEALTH 139, 140 (2000) (statement of Sen. Pete Domenici) (noting “I don’t want anyone . . . out of business because of a mandate.”); Kjorstad, supra, at 36 (maintaining concessions necessary for parity law to pass minimized its effect). 18 See U.S. GEN. ACCOUNTING OFFICE, supra note 10, at 5, 11. As of December 1999, 86% of employers reported that the benefits they offered to their employees conformed to the MHPA federal parity requirement. Id. at 11. This was a significant improvement from the 55% of employers that offered parity in dollar limits before the MHPA was enacted. Id. However, to offset the required enhancements of the parity law, employers incorporated more restrictive design features and higher cost-sharing provisions into the mental health benefits they offered. Id. at 12-14. Of the 86% of plans in compliance with the MHPA in December 1999, 87% contained at least one feature, such as service limits or high cost sharing, which restricted mental health benefits to a greater degree than other physical health benefits. Id at 12.

19 Substance Abuse Treatment Parity: A Viable Solution to the Nation’s Epidemic of Addiction?: Hearing Before the Subcomm. on Criminal Justice, Drug Policy, and Human Resources of the House Comm. on Government Reform, 106th Cong. 6 (1999) (“House Hearing 1999”) (statement of Sen. Wellstone). Less than 10% of the American workforce had access to health insurance that provided equal coverage for addiction diseases. David C. Lewis, Limits on Substance Abuse Benefits and the Quest for Parity with Other Chronic Diseases, BROWN U. DIG. ADDICTION THEORY & APPLICATION, 12, 12 (1996).


21 See Sonja B. Starr, Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction

Significantly, the MHPAEA modified the health parity requirements of the MHPA to include equal coverage of not only annual and lifetime dollar limits but also day and visit restrictions, cost sharing features, and in-network and out-of-network

_Treatment_, 111 YALE L.J. 2321, 2359 (2002) (noting absence of substance abuse language from MHPA prompted renewed substance abuse parity effort). During Congressional debates, Representative Patrick Kennedy argued, regarding substance addiction:

"This is a physical disease, because this is a compulsion of the mind, of the body of the soul. And unless our country comes to grips with treating this disease for what it is, and that is a physical illness, like every other physical illness, then we as a society will not begin to address all of the other problems that we hear our colleagues come to the floor this evening to talk about."


"It's time to end the higher copayments, higher deductibles, the out-of-pocket costs and limited treatment stays. It's time to end those discriminatory barriers that don't exist for other physical diseases. It's time to treat mental illness and chemical addiction under the same rules as physical illnesses. After all, it was 1946 when the American Medical Association categorized addiction as a disease. Anybody from the Flat Earth Society who still thinks it's a moral failing, I suggest they consult the American Medical Association, our Nation's doctors, who, as long ago as 1956, realized addiction is a disease."

_id. at 15450 (statement of Rep. Ramstad).


services, and extended the application of such requirements to substance use disorder benefits. While a momentous victory for substance use disorder parity, the MHPAEA was not free of deficiencies. Most notably, the law did not mandate substance use disorder coverage but only prevented employers offering such benefits from implementing less favorable limitations than those imposed on physical health services. Moreover, exemptions such as those for small employers and individuals remained, effectively making the law applicable only to large employers. Among such large employers, in 2009 and 2010 after the MHPAEA went into effect, significant percentages continued to impose more restrictive financial requirements and treatment limitations for substance use disorder benefits compared with physical health benefits. These limitations help shed light on why, despite the great strides made by federal lawmakers, the rate and number of individuals in the American population receiving any substance use disorder treatment remained unchanged for a decade between 2002 and

24 See Pub. L. No. 110-343 (codified at 42 U.S.C. § 201; 29 U.S.C. § 1185a; 42 U.S.C. § 300gg–5; 42 U.S.C. § 300gg–26; 26 U.S.C. § 9812). See H.R. Rep. No. 110-374 pt. 2, at page 12, 14-17 (2007) (explaining what the MHPAEA involved). 25 See infra notes 26-27 and accompanying text (explaining what MHPAEA lacked to guarantee full substance use disorder parity). 26 See Pub. L. No. 110-343 (codified at 42 U.S.C. § 300gg–26(b)). “Nothing in this section shall be construed . . . as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits . . . .” Id. 27 See Pub. L. No. 110-343 (codified at 42 U.S.C. § 201; 29 U.S.C. § 1185a; 42 U.S.C. § 300gg–5; 42 U.S.C. § 300gg–26; 26 U.S.C. § 9812). The MHPAEA modified the small employer exemption; a “small employer” included both employers with 2-50 employees and, with respect to states that allow small groups to include one person, employers with, on average, at least one employee during the preceding calendar year. H.R. Rep. No. 110-374 pt. 2, at 18 (2007). 28 See Eric GoPlerud, U.S. DEP’T OF HHS, 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 24-33 (2013), available at http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.pdf. In 2009, the percent of plans that imposed more restrictive substance use disorder benefits as compared with physical health benefits were as follows: 6.4% imposed more restrictive inpatient in-network financial requirements; 11.1% imposed more restrictive inpatient out-of-network financial requirements; 24% imposed more restrictive outpatient in-network financial requirements; 22.3% imposed more restrictive outpatient out-of-network financial requirements; 46.2% covered fewer substance use disorder in-network inpatient days; 40.4% covered fewer substance use disorder out-of-network inpatient days; 51.1% covered fewer substance use disorder outpatient days; 53.2% covered fewer substance use disorder out-of-network outpatient days; 9.4% applied more restrictive annual dollar limits for outpatient in-network care; and 9.8% applied more restrictive annual dollar limits for outpatient out-of-network care. Id. at 24 Tables.9-10, 32 Tables 21-22, 33 Tables 23-24. The figures for the respective categories were as follows in 2010: 5.3%, 5.8%, 20.8%, 6.8%, 13.8%, 12.7%, 14%, 1.5%, and 2.9%. Id. Thus, although percentages improved from 2009 to 2010, full parity was still yet to be achieved. Id.
II. Substance Use Disorder Coverage Under the ACA

On March 23, 2010, President Barack Obama signed the ACA into law. The comprehensive health care bill puts into place various insurance reforms to be implemented periodically through 2019. Significantly, such reforms include provisions that build upon the MHPAEA and regulate new standards for coverage and treatment of substance use disorders. Overall, the ACA aims to expand accessibility and parity of substance use disorder benefits by: (1) expanding health coverage to millions of previously uninsured Americans; (2) requiring that substance use benefits are included in the Essential Health Benefits ("EHB") of most individual and fully insured small group plans; (3) setting lifetime limits on dollar value of health insurance coverage; (4) mandating coverage of specific preventive services for infants, children, and adults without cost-sharing; (5) extending coverage for dependent children to age twenty-six for all individual and group policies; (6) requiring establishment of state-based health benefit exchange marketplaces effective January 1, 2014. And still more have been delayed to 2015 and beyond.

See supra note 2 and accompanying text (discussing ACA provisions related to substance use disorder parity).
plans; and (3) applying federal parity rules to such benefits.33

A. ACA Mandates

Through an individual and an employer shared responsibility provision, the ACA mandates that most Americans have health insurance as of 2014.34 Although particular individual exemptions and a small employer group exception exist, the Congressional Budget Office ("CBO") estimates that by 2019 the ACA mandates will increase the number of Americans with health insurance by at least twenty-five million and by as much as thirty-two million.35

1. Individual Responsibility

Effective in 2014, the ACA requires most United States citizens to have health insurance coverage or otherwise incur a penalty for noncompliance.36 Those individuals

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36 See ACA § 1501(a) (codified as amended at 42 U.S.C. § 18091); ACA § 1501(b) (codified as amended at 26 U.S.C. § 5000A); ACA § 1501(d) (noting “[a]mendments made by this section
subject to the law must maintain "minimum essential coverage," which includes coverage under a government-sponsored plan, an employer-sponsored plan, a "qualified plan" obtained through the newly created health insurance exchanges, or a "grandfathered health plan." 37 Early figures, based on 2012-2013 census data and

shall apply to taxable years ending after December 31, 2013"). See also Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566 (2012). In 2012, the United States Supreme Court held that although the individual mandate was not a valid exercise of Congress's power under the Commerce Clause or the Necessary and Proper Clause, it was a constitutional exercise of Congress's authority to levy taxes. Id. The penalty, assessed on a monthly basis and included in the taxpayer's return for the taxable year including that month, will be calculated as the lesser of: (1) the sum of "monthly penalty amounts" for months in the taxable year during which failure(s) to maintain coverage occurred, or (2) an amount equal to the national average premium for a health plan offered through the exchanges, for the applicable family size, and qualified as "bronze" by covering 60% of the total costs of benefits under the plan. ACA § 1501(b) (codified as amended at 26 U.S.C. §§ 5000A(b), (c)(1); ACA § 1302 (codified as amended at 42 U.S.C. § 18022(d)(1)(A)). The monthly penalty amount is calculated as one twelfth of the greater of: (1) a flat dollar amount assessed on each taxpayer and his or her dependents, or (2) a percentage of household income above the applicable filing threshold for the tax year. ACA § 1501(b) (codified as amended at 26 U.S.C. § 5000A(c)(2)). For 2014, the dollar amount is $95 and the percentage is 1%; in 2015, the figures rise to $325 and 2%; in 2016, they equal $625 and 2.5%; and in the following years, the amounts will be formulated based on a cost-of-living adjustment. ACA § 1501(b) (codified as amended at 26 U.S.C. §§ 5000A(c)(2), (3)). See also Annie L. Mach, Individual Mandate Under ACA, CONGRESSIONAL RESEARCH SERVICE, R41331, (2014).

37 See ACA § 1501(b) (codified as amended at 26 U.S.C. §§ 5000A(a), (f)). "Minimum essential coverage" is statutorily defined as: (1) Coverage under a government-sponsored plan, such as Medicare part A, Medicaid, the State Children's Health Insurance Program (CHIP), TRICARE, a Department of Veterans Affairs (VA) health care program, a health care plan relating to Peace Corps volunteers (under 22 U.S. C. §2504(e)) or the Nonappropriated Fund Health Benefits Program of the Department of Defense; (2) Coverage through an employer-sponsored plan; (3) Plans obtained in state individual marketplaces; (4) Grandfathered health plans; or (5) Any other coverage that the Secretary of Health and Human Services recognizes. ACA § 1501(b) (codified as amended at 26 U.S.C. § 5000A(f)). Other types of coverage designated in the final regulations as minimum essential coverage include: (1) Refugee Medical Assistance supported by the Administration for Children and Families; (2) Medicare Advantage plans; (3) State high-risk pools for plan or policy years beginning on or before December 31, 2014; and (4) Self-insured student health plans for plan or policy years beginning on or before December 31, 2014. Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions; Final Rule, 78 Fed. Reg. 39494, 39514-39516 (July 1, 2013) (codified at 45 C.F.R. pts. 155, 156). The health insurance exchanges are new health insurance marketplaces that Americans can use to shop for qualified health plans. Id. at 39494. A "qualified health plan" is a health insurance plan that: (1) Is certified by the health insurance exchange that it is offered through; (2) Provides the EHB package; and (3) Is offered by a health insurance issuer that is licensed and in good standing in the State in which it is offering coverage, offers plans that comply with established limits on cost-sharing, charges the same premium rate for each health plan whether the plan is offered through an exchange or purchased directly from the issuer, and complies with other requirements that an applicable exchange may establish. ACA § 1301(a); Glossary: Qualified Health Plan, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/qualified-health-plan/ (last visited Dec. 3, 2014). See also infra notes 64-65 (defining and discussing EHB); infra notes 67, 69-70, 79 (defining and discussing
projected enrollment effects under the ACA, suggest that over fifty percent of nonelderly Americans will have employer-sponsored coverage, roughly twenty-five to thirty percent will have government-sponsored coverage, and about six million, or two percent, will purchase coverage via an exchange through 2014. Unfortunately, exact data for the overall percentage of Americans enrolled in grandfathered health plans, whether employer-sponsored or individually purchased, is not available, but numbers are predicted to decrease over time.

Continued access to a Section 125 Premium Only Plan, an IRS-approved benefit that allows employees to pay their portion of health insurance premiums on a pre-tax basis, may be one reason for the prominence of employer-sponsored group health insurance coverage. Under such Premium Only Plans, which are available to all employers regardless of size, employees reduce their taxable income, thereby lowering their taxes and increasing their take-home pay, and employers cut their payroll and tax liability by decreasing their total taxable payroll. Although federal law previously permitted employers to use Premium Only Plans to help employees make pre-tax

38 See CONGRESSIONAL BUDGET OFFICE, supra note 35 and accompanying text (discussing enrollment in required coverage); Health Insurance Coverage of the Total Population, THE HENRY J. KAISER FAMILY FOUNDATION, http://kff.org/other/state-indicator/total-population/# (last visited Dec. 4, 2014); Carmen DeNavas-Walt et al., U.S. CENSUS BUREAU, P60-245, Income, Poverty, and Health Insurance Coverage in the United States: 2012, 67 (2013), available at http://www.census.gov/prod/2013pubs/p60-245.pdf. Enrollment distributions are expected to change as more Americans purchase coverage through exchanges. See CONGRESSIONAL BUDGET OFFICE, supra note 35. For example, 4.7%, 7.9%, and 8.6% of Americans are predicted to purchase health coverage through an exchange in 2015, 2016 and 2017, respectively. See id.

39 See infra note 72 (noting lack of comprehensive data source related to grandfathered health plan cancellations); infra text accompanying notes 72-73, 84 (projecting greater numbers of grandfathered health plans will lose privileged status in coming years).

40 See 26 U.S.C. §§ 125(a), (d)(1), (f)(1) (2012). “[N]o amount shall be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan.” Id. § 125(a). “[C]afeteria plan’ means a written plan under which . . . all participants are employees, and . . . the participants may choose among 2 or more benefits consisting of cash and qualified benefits.” Id. § 125(d)(1). “[Qualified benefit’ means any benefit which, with the application of subsection (a), is not includible in the gross income of the employee by reason of an express provision of this chapter. Id. § 125(f)(1).

purchases of either employer-sponsored or individual health insurance coverage, effective January 1, 2014, the ACA prohibits the use of such plans with respect to individual insurance coverage purchased through a health insurance exchange.\textsuperscript{42}

Certain categories of individuals are not required to maintain minimum essential coverage and are exempt from the individual shared responsibility penalty.\textsuperscript{43} The coverage mandate does not apply to individuals who decline coverage for religious reasons, those who are part of a Health Care Sharing Ministry, individuals not lawfully present in the United States, or the incarcerated.\textsuperscript{44} Further, exemption from the penalty is available for individuals whose required contribution exceeds eight percent of household income, those whose household income is below the filing threshold for federal income taxes, members of Indian tribes, those without coverage for less than three consecutive months, and those determined by the Secretary of Health and Human Services to have suffered a hardship obtaining health coverage under a qualified plan.\textsuperscript{45}


26 U.S.C. § 125(f)(3). Thus, while employers can continue use Premium Only Plans with respect to employer-sponsored coverage purchased on a health insurance exchange, they can no longer use Premium Only Plans to help employees purchase individual health insurance coverage on a health insurance exchange with pre-tax dollars.

\textit{See id.}; CORE DOCUMENTS, supra.


\textsuperscript{44} ACA § 1501(b) (codified as amended at 26 U.S.C. § 5000A(d)); 45 C.F.R. § 155.605(c)-(e).

\textsuperscript{45} ACA § 1501(b) (codified as amended at 26 U.S.C. § 5000A(e)); 45 C.F.R. § 155.605(f)-(g). Individuals may qualify for a hardship exemption if they experience any of the following: (1) Homelessness; (2) Eviction in the past 6 months, or facing eviction or foreclosure; (3) Receipt of a shut-off notice from a utility company; (4) Recent domestic violence; (5) Recent death of a close family member; (6) Fire, flood, or other natural human-caused disaster that lead to substantial damage to their property; (7) Filing for bankruptcy in the last 6 months; (8) Incurred unreimbursed medical expenses they couldn’t pay for in the last 24 months; (9) Unexpected increase in necessary expenses due to caring for an ill, disabled, or aging family member; (10) Expecting to claim a child as a tax dependent who’s been denied coverage in Medicaid and
The CBO estimates that in 2016, once the major provisions of the ACA goes into effect, twenty-four million Americans will be exempt from the individual mandate.46 Given population projections for 2016, this figure translates into roughly seven percent of the American population exempt from the ACA’s individual mandate.47

2. Large Employer Group Responsibility

The ACA also includes an employer shared responsibility provision.48 As originally enacted, the health care law stipulated that large employers with at least fifty "full-time equivalent employees" were required to provide affordable, minimum essential coverage to their full-time employees, or face a penalty beginning in 2014.49 In

CHIP, and another person is required by court order to give medical support to the child; (11) Resulting from an eligibility appeals decision, the individual is eligible either for enrollment in a qualified health plan through the Marketplace, lower costs on their monthly premiums, or cost-sharing reductions for a time period when they were not enrolled in a qualified health plan; (12) Determined ineligible for Medicaid because the individual's state did not expand eligibility for Medicaid under the ACA; (13) Receipt of a notice saying that their current health insurance plan is being cancelled, and the individual considers the other plans available unaffordable; or (14) Other hardship in obtaining health insurance. See 45 C.F.R. § 155.605(g)(1); U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., OPTIONS AVAILABLE FOR CONSUMERS WITH CANCELLED POLICIES (Dec. 19, 2013), available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf; OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, OMB No. 0938-1190, APPLICATION FOR EXEMPTION FROM THE SHARED RESPONSIBILITY PAYMENT FOR INDIVIDUALS WHO EXPERIENCE HARDSHIPS (2014), available at http://marketplace.cms.gov/applications-and-forms/hardship-exemption.pdf.

46 See CONG. BUDGET OFFICE, PAYMENTS OF PENALTIES FOR BEING UNINSURED UNDER THE AFFORDABLE CARE ACT (2012), available at http://cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv_Mandate_Penalty.pdf. The CBO estimates that thirty million nonelderly Americans will be uninsured in 2016, but that the majority of them, twenty-four million, will be exempt from the individual mandate penalty tax. Id. Between eighteen to nineteen million will qualify for exemptions because they will have income low enough that they are not required to file an income tax return, the premium they would have to pay for insurance would exceed eight percent of their income, or they are members of Indian tribes. Id. Of the remaining eleven to twelve million uninsured Americans, all but six million will be granted exemptions either on the basis of their religion or because of hardship. Id.


49 See ACA § 1513(a) (codified as amended at 26 U.S.C. §§ 4980H(a), (c)(2)(A)); ACA § 1513(d).

The law provides:

If . . . any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential
July 2013, the Obama Administration announced that it would delay the employer mandate penalties until 2015 and in February 2014, the Department of the Treasury

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

ACA § 1513(a) (codified as amended at 26 U.S.C. § 4980H(a)). “Applicable large employer” is defined as, “[W]ith respect to a calendar year, an employer who employed an average of at least fifty full-time employees on business days during the preceding calendar year.” ACA § 1513(a) (codified as amended at 26 U.S.C. § 4980H(c)(2)(A)). A full-time employee is one who worked, on average, at least thirty hours per week with respect to any month. ACA § 1513(a) (codified as amended at 26 U.S.C. § 4980H(c)(4)(A)). Full-time equivalent employees, determined based on hours of service of part-time employees, are also taken into account in determining whether an employer is an applicable large employer:

Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

ACA § 1513(a) (codified as amended at 26 U.S.C. § 4980H(c)(2)(E)). Final regulations, noting that the average month consists of more than four weeks, adopt a standard of 130 hours of service per calendar month for determining full-time equivalent employee status rather than 120 hours per month. Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 8544, 8553 (Feb. 12, 2014) (to be codified at 26 CFR pts. 1, 54, 301). Thus, large employer status is calculated by dividing the combined hours worked by part-time employees during a month by 130 and adding the number of full-time employees (i.e. those working over thirty hours per week).

ACA § 1401(a) (codified as amended at 26 U.S.C. § 36B(c)(2)(C)); MULVEY, supra, at 3. An employee may be eligible for a premium tax credit if his or her income is below a certain threshold and his or her large employer: (1) does not offer coverage, or (2) offers health insurance coverage that is not “affordable” or does not provide “minimum value.” ACA § 1401(a) (codified as amended at 26 U.S.C. § 36B(c)(2)(C)); MULVEY, supra, at 3-4. Coverage is affordable if the employee’s contribution is less than 9.5% of his or her household income. ACA § 1401(a) (codified as amended at 26 U.S.C. § 36B(c)(2)(C)(i)). Coverage meets minimum value if the plan covers at least 60% of the total cost of benefits provided under the plan. ACA § 1401(a) (codified as amended at 26 U.S.C. § 36B(c)(2)(C)(ii)). Finally, section 1513(d) of the ACA provides that the employer shared responsibility mandate and penalty, section 1513(a) of the ACA, codified as amended at section 4890H of the Internal Revenue Code, “shall apply to months beginning after December 31, 2013.” ACA § 1513(d), Pub.L. 111-148, 124 Stat. 119 amended by 26 U.S.C § 4890H.
issued final rules detailing further postponement in implementation.\textsuperscript{50} Under the new rules, employers with one hundred employees or more must offer coverage to at least 70\% of full-time workers beginning in 2015 and 95\% in 2016 or face a penalty; employers with fifty to ninety-nine employees do not have to offer coverage or pay any penalties until 2016.\textsuperscript{51} However, notwithstanding the delays, of the employers with fifty or more employees, which make up about 4\% of all employers in the United States, 91\% offered health coverage to employees in 2013.\textsuperscript{52}


\textsuperscript{51} See \textit{Shared Responsibility for Employers Regarding Health Coverage}, Treas. Reg. § 9655, (2014). With respect to employers with 100 or more full-time equivalent employees, the final rules provide that an "applicable large employer member is treated as offering coverage to its full-time employees... for a month if, for that month, it offers coverage to all but five percent or, if greater, five, of its full-time employees." \textit{Id.} at 8565.

As further transition relief, for each calendar month during 2015 and any calendar months during the 2015 plan year that fall in 2016, an applicable large employer member that offers coverage to at least 70\% (or that fails to offer to no more than 30\%) of its full-time employees... will not be subject to an assessable payment under section 4980H(a).

\textit{Id.} at 8575. The final rules provide different, even more lenient rules for employers with fifty to ninety-nine full-time equivalent employees:

A large percentage of those employers [affected by section 4980H of the Internal Revenue Code] are in the smaller size range, such as those with fewer than 100 full-time employees (including FTEs). To assist these employers in transitioning into compliance with section 4980H, the transition relief described below is provided for all of 2015 plus, in the case of any non-calendar plan year that begins in 2015 (2015 plan year), the portion of that 2015 plan year that falls in 2016. For employers eligible for the transition relief described in this section XV.D.6, no assessable payment under section 4980H(a) or (b) will apply for any calendar month during 2015 or any calendar month during the portion of the 2015 plan year that falls in 2016.

\textit{Id.} at 8574.

3. Small Employer Group Lack of Responsibility

Small group employers with fewer than fifty full-time employees are exempt from the employer shared responsibility requirement and therefore do not have to provide coverage to employees. Approximately 96% of employers fall within this definition.

Shortly following passage of the ACA, the Department of the Treasury, Department of Labor ("DOL"), and Department of Health and Human Services ("HHS") reported there were roughly 2.8 million small group health plans and 40.9 million participants and beneficiaries in such plans. In terms of percentages, 59% of employers with three to nine employees, 76% of employers with ten to twenty-four employees, and 92% of employers with twenty-five to forty-nine employees offered health benefits in 2010. Further, among those small employers offering health benefits, the percentages of eligible employees who participated in their employers' plan were as follows: 76% in companies with three to nine employees, 77% in companies with ten to twenty-four employees, and 79% in companies with twenty-five to forty-nine employees. Thus, the majority of small businesses offered, and the majority of eligible


See ACA § 1513(a) (codified as amended at 26 U.S.C. §§ 4980H(c), (c)(2)(A)); Shared Responsibility for Employers Regarding Health Coverage, Treas. Reg. § 9655 (2014); Fact Sheet, U.S. Dep't of the Treasury, Final Regulations Implementing Employer Shared Responsibility Under the Affordable Care Act (ACA) for 2015 1 (2014), available at http://www.treasury.gov/press-center/press-releases/Documents/Fact%20Sheet%20021014.pdf. The employer shared responsibility mandate applies only to large employers, which, for purposes of the mandate, are defined as those employers "who employed an average of at least 50 full-time employees on business days during the preceding calendar year." ACA § 1513 (codified as amended at 26 U.S.C. § 4980H(c)(2)(A)). Thus, employers with fewer than fifty full-time employees are considered, at enactment of and through the lifespan of the ACA, to be exempt small employers. See Press Release, U.S. Dep't of the Treasury, supra note 52 (discussing the final regulations for the Employer Shared Responsibility under the ACA).

See Press Release, U.S. Dep't of the Treasury, supra note 52 (discussing the final regulations for the Employer Shared Responsibility under the ACA).


See id. at 49 Exhibit 3.2. Not all employees are eligible for participation in their employer's
employees participated in, employer-sponsored health care.58

The statistics reported at the close of 2013 reveal similar clear trends among small business employers and employees.59 For instance, 45% of employers with three to nine employees, 68% of employers with ten to twenty-four employees, and 85% of employers with twenty-five to forty-nine employees offered health benefits through 2013.60 For those small employers not offering health benefits to their employees, 50% cited the high cost of health insurance as the most important reason for not doing so.61 Among those small employers offering health coverage, 75% of eligible employees in companies with three to twenty-four employees participated in their employers’ plan, compared with 77% in companies with twenty-five to forty-nine employees.62 Thus, in the three years from 2010 to 2013, slight decreases in the number of small employers offering health benefits to their employees occurred while the number of eligible employees eager to participate in such plans remained relatively stable.63

B. Essential Health Benefits

In addition to the coverage mandates, the ACA also requires certain insurers to provide an EHB package effective January 1, 2014.64 The EHB package covers ten

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health coverage. Id. at 46. Moreover, not all eligible employees offered coverage elect to participate. Id. In 2010, the percentage of employees eligible for health benefits offered by their employer and the percentage of eligible employees participating in their employers’ plan were, respectively: (1) For employers with three to twenty-four employees, 83% and 76%; (2) for employers with twenty-five to forty-nine employers, 84% and 77%. Id. at 49 Exhibit 3.2. Thus, eligible employees that are offered health benefits generally elect to take up such benefits. Id. at 46.

58 See supra notes 55-57 and accompanying text (reporting the number of small employers offering health care and subsequent participation percentages for 2010).
59 See infra text accompanying notes 60-63 (presenting 2013 statistics and describing changes since 2010).
60 See KAIser 2013, supra note 52, at 38 exhibit 2.2.
61 Id. at 43 exhibit 2.9. Other reasons included: the firm is too small (16%), employees are generally covered under another plan (15%), employee turnover is too great (1%), no employee interest (5%), most employees are part-time or temporary (8%), other (5%), and don’t know (1%). Id.
62 Id. at 49 exhibit 3.2. The percentage of employees eligible for health benefits and the percentage of eligible choosing to participate were, respectively: (1) For employers with three to twenty-four employees, 84% and 75%; (2) For employers with twenty-five to forty-nine employees, 81% and 77%. Id.
63 Compare supra text accompanying notes 56-57 (detailing 2010 statistics), with supra text accompanying notes 60-62 (detailing 2013 statistics).
benefit categories, one of which is substance use disorder services.\textsuperscript{65}

1. Individual Marketplace EHB Requirement

First, the EHB rule applies to all non-grandfathered health plans in the individual marketplace.\textsuperscript{66} A grandfathered health plan is a health plan in which an individual was enrolled in on or before March 23, 2010.\textsuperscript{67} As of January 2010, 10.8

\textsuperscript{65} ACA § 1302(b)(1) (codified as amended at 42 U.S.C. § 18022(b)(1)). The law provides:

\textbf{[T]he Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory services. (I) Preventive and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.}

\textit{Id.}

\textsuperscript{66} See ACA § 1251(a), (e) (codified as amended at 42 U.S.C. § 18011(a), (e)) (providing grandfathered health plan exemption from general individual marketplace EHB requirement); Preservation of Right to Maintain Existing Coverage, 29 C.F.R. § 2590.715-1251 (2010) (defining grandfathered health plan); \textit{supra} note 64 and accompanying text (explaining how EHB requirement applies to individual marketplace). The ACA states:

\textit{Nothing in this Act (or an amendment made by this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act. . . . [and, further] [w]ith respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle [relating to quality health insurance coverage for all Americans] and subtitle A [relating, among other things, to the EHB package] (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.}

ACA § 1251(a) (codified as amended at 42 U.S.C. § 18011(a)).

\textsuperscript{67} 29 C.F.R. § 2590.715–1251(a)(1). \textit{“Grandfathered health plan coverage means coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section).”} \textit{Id.}
millions of Americans had non-group, or individually purchased, coverage. Although individuals can no longer newly enroll in a health plan after March 23, 2010 and enjoy grandfathered status, insurance companies currently may renew grandfathered plans effective before this date provided no changes to the plan are made which would cause the plan to lose its grandfathered status. Importantly, insurance companies are not required to continue availability of grandfathered health plans. From an insurance


69 29 C.F.R. § 2590.715–1251(a); WHAT TO KNOW ABOUT INSURANCE COVERAGE CANCELLATION LETTERS, DEPT OF HEALTH AND HUMAN SERVS. (2014), available at http://marketplace.cms.gov/outreach-and-education/cancellation-letters.pdf; Grandfathered Health Insurance Plans, HEALTHCARE.Gov, https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/#question=can-a-plan-lose-its-grandfathered-status (last visited Nov. 30, 2014). Grandfathered health plans can maintain their grandfathered status as long health insurance companies provide individuals with yearly notice of the plan’s grandfathered status and as long as the plan has not significantly reduced benefits or increased costs. 29 C.F.R. § 2590.715–1251(a), (g); INSURANCE COVERAGE CANCELLATION LETTERS, supra. The regulations state:

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

29 C.F.R § 2590.715–1251(a)(2)(i). Certain changes to the terms of a health plan may cause the plan to cease to be a grandfathered health plan. 29 C.F.R § 2590.715–1251(g); Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 3453, 34543–34545 (June 17, 2010). These changes include: the “elimination of all or substantially all benefits to diagnose or treat a particular condition”; increases in the level of percentage cost-sharing, such as an individual’s coinsurance requirement, which significantly alters the level of benefits provided; increases in fixed-amount cost-sharing other than a copayment, such as an individual’s deductible or out-of-pocket limit, which are greater than the maximum percentage increase (defined as medical inflation plus fifteen percentage points); increases in fixed-amount copayments if the total increase in the copayment exceeds the greater of (A) the maximum percentage increase or (B) $5 increase by medical inflation; and/or certain changes in annual limits in the dollar value of benefits by a plan, such as (A) imposition of a new annual limit, (B) with regard to plans that imposed a lifetime limit but no annual limit as of March 23, 2010, adoption of an annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010, or (C) with regard to plans that imposed an annual limit as of March 23, 2010, any decrease in the dollar value of the annual limit. 29 C.F.R § 2590.715–1251(g)(1)(i)-(iv), (vi); Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 34543-34545.

70 29 C.F.R § 2590.715–1251. While the law states that if a plan is changed, individuals must be
company's perspective, grandfathered health plans are less attractive than non-grandfathered plans which can be offered to new consumers on or off the health insurance exchanges, and whose plan design can be modified based on market conditions to generate greater profit. Given such restrictive marketability and profitability, compilations of state data suggest that insurance carriers will discontinue upwards of four to five million individual grandfathered health plans in 2014. Moreover, the Obama Administration projects that an additional 40% to 67% of individually purchased plans will lose grandfathered status solely due to the high turnover of participants and insurance arrangements that characterize this market.

2. Large Employer Group Lack of EHB Requirement

Unlike the individual marketplace, the ACA EHB requirement does not apply in offered and need to choose a new plan, it does not mandate that health insurers either maintain or cancel plans with grandfathered status. If an insurance company stops offering a grandfathered plan, the insurance company must provide notice ninety days before the plan ends and provide enrollees with available coverage options. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of the U.S. Code); Grandfathered Health Insurance Plans, supra note 69.

The only insurers entitled to join the exchange[s] have to meet certain key requirements: for example, the kinds of coverage they have to supply, the persons to whom they must supply it, and the number and types of individuals they have to enroll. The fixes here standardize some portion of the insurance deal in ways that undermine the ability of innovative firms to gain greater market share by altering the type of coverage that they choose to supply.


Because there is no comprehensive source of data related to grandfathered health plan cancellations, and because many states lack the resources and intent to monitor cancellations and require issuers to report relevant data, “such information is available in a patchwork fashion, at best.” Fernandez & Mach, supra at 5. Some states have tracked the cancellation notifications through their insurance departments or health care exchanges and in other states the largest private insurers released the number of discontinuation notices they issued, but twenty states report they do not have the information or are not tracking it. Policy Notifications and Current Status, supra. Based on this mix of information, reports claim that at least 4.7 million Americans received cancellation notices by the close of 2013. Id.

Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34553.
the large employer group health insurance market. Although neither the MHPAEA nor the ACA require large employers to offer substance use disorder coverage, available data shows that a majority of large employers nevertheless offer substance use disorder coverage to their employees. For example, the Henry J. Kaiser Family Foundation reported that at the close of 2010, only 5% of large employers dropped substance use disorder coverage; similarly, the U.S. Government Accountability Office found that between 2010 and 2011, 96% of large employers offered substance use disorder coverage to employees.

C. Small Employer Group EHB Requirement

Finally, the EHB requirement applies in the small employer group health insurance market. Specifically, the EHB requirement applies to non-grandfathered, fully-insured small employer group health plans.

Interim final rules released by HHS specify that small group health plans that make significant changes to a grandfathered health plan's benefits, cost-sharing structure, employer-employee contributions, or annual limits will forfeit their grandfathered status, thus becoming subjected to all of the ACA requirements including the EHB package requirement. Small employers frequently tend to make substantial


75 See infra text accompanying note 76 (detailing percentage of large employers that offer substance use disorder coverage to employees).


77 ACA § 1201(2)(A) (codified as amended at 42 U.S.C. § 300gg-6) (“[H]ealth insurance issuer . . . in . . . small group market shall ensure . . . coverage includes the essential health benefits...”).


79 See supra note 69; 29 C.F.R § Preservation of Right to Maintain Existing Coverage, 29 C.F.R. §
changes to such features of their health plans in order to control rising premium costs.\footnote{See Gary Claxton et al., Employer Health Benefits, THE HENRY J. KAISER FAMILY FOUND. 187 exhibit 13.3(2011), available at http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8225.pdf ("KAISER 2011"). Among non-grandfathered small employer group health plans, responses explaining why the plan is not a grandfathered health plan were as follows: 18% said benefits changed more than the law allows; 24% said deductibles or copayments changed more than the law allows; 15% said employer-employee premium contributions changed more than the law allows; and 11% said provider networks have changed more than the law allows. \textit{Id}.}

Given this, of the 2.8 million small group health plans and the 40.9 million people insured under such at the time the ACA was passed, the Obama Administration projected that 49\% to 80\% would transition from their current plan to a fully compliant ACA plan over the next several years.\footnote{Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34553 (June 17, 2010).} The available data from 2011 to 2013 demonstrates that the administration predicted correctly—many small employers have chosen to relinquish their privileged status rather than live within the ACA

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\item 2500.715–1251 (2010); Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34543-34544 (June 17, 2010). Small employer group health plans can lose grandfathered status in the same ways that individually purchased health plans can lose grandfathered status: (1) Elimination of all or substantially all benefits to diagnose or treat a particular condition; (2) Any increase in a percentage cost-sharing requirement, such as coinsurance; (3) Defined increases in fixed-amount cost-sharing requirements other than a copayment, such as deductibles and out-of-pocket limits; (4) Defined increases in a fixed-amount copayment; (5) Defined changes to annual or lifetime limits on the dollar value of all benefits. \textit{See supra} note 69. Additionally, small employer group plans can lose grandfathered status if the employer's contribution rate toward coverage is based on the cost of coverage or on a formula (such as hours worked), and the employer decreases contribution towards the cost of any tier of coverage for any class of similarly situated individuals by more than five percentage points below the contribution rate on March 23, 2010. 29 C.F.R § 2590.715–1251(g)(1)(v); Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34543-34544. Changes that will not cause a plan to lose grandfathered status include: (1) Termination of coverage of one or all of the individuals enrolled in the plan on March 23, 2010, provided the plan continuously covered someone since March 23, 2010; (2) Enrollment of new family members in the plan after March 23, 2010, provided the family members are dependents of an individual who was enrolled in the plan on March 23, 2010; (3) Enrollment of newly hired employees and the enrollment of existing employees eligible for new enrollment after March 23, 2010; and (4) Entering into a new policy, certificate, or contract of insurance (i.e., changing insurance carriers) after March 23, 2010. 29 C.F.R § 2590.715–1251(g)(1)(v); Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34543-34544; Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70114, 70116-70117 (Nov. 17, 2010). Mark Merlis, 'Grandfathered' Health Plans, HEALTH AFFAIRS (Oct. 29, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=29.
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grandfathered plan limits.\textsuperscript{82} In 2011, 76\% of small employers with three to twenty-four employees and 54\% of small employers with twenty-five to forty-nine employees offered a plan grandfathered under the ACA; by 2013, these numbers fell to 56\% and 52\%, respectively.\textsuperscript{83} Moreover, of those employers still offering a grandfathered plan at the close of 2013, less than half anticipate keeping such status beyond 2014.\textsuperscript{84}

Just as the EHB requirement does not apply to small employer grandfathered health plans, it also does not apply to small employer self-funded health plans.\textsuperscript{85} Under a self-funded or self-insured health insurance plan, rather than pay a pre-determined premium to an insurance carrier for a fully-insured plan, an employer assumes the financial risk for providing health benefits to employees and pays medical claims out-of-pocket directly to doctors and hospitals as employees incur such.\textsuperscript{86} The employer typically contracts with a third-party administrator to establish and manage a provider network, process claims, issue membership cards, and perform other services that

\textsuperscript{82} See infra text accompanying notes 83-84 (providing grandfathered health plan statistics 2011 through 2013).

\textsuperscript{83} Compare KAISER 2011, supra note 80, at 185 exhibit 13.1 (detailing 2011 grandfathered health plan statistics), with KAISER 2013, supra note 52, at 197 exhibit 13.1 (detailing 2013 grandfathered health plan statistics).


Of employers with grandfathered health plans, 44.6\% do not expect to lose grandfathered status by the end of 2014, 31.3\% expect to lose grandfathered status by the end of 2014, and 21.7\% are not sure. \textit{Id.}

\textsuperscript{85} See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 1302(a) (March 23, 2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010) (codified as amended in scattered sections of 26, 42 U.S.C. (2013)); ACA § 1301(b)(1) (codified as amended at 42 U.S.C.A. § 18021(b)(1)(B)); ERISA § 514. Section 1302 of the ACA, which describes the EHB requirement, provides: “In this title, the term ‘essential health benefits’ means, \textit{with respect to any health plan...}” ACA § 1302(a) (codified as amended at 42 U.S.C.A. § 18022(a)) (emphasis added). However, section 1301 of the law excludes self-insured plans from the definition of “health plan” when it states: “Except to the extent specifically provided by this title, the term ‘health plan’ shall not include a group health plan... to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of ERISA.” ACA § 1301(b)(1) (codified as amended at 42 USCA § 18021(b)(1)(B)); ERISA § 514(b)(2)(B) (exempting employee benefit plans described in 29 U.S.C. § 1003(a), i.e. self-funded plans, from state insurance regulation).

insurance carriers offering fully-insured health plans conduct. Moreover, self-funded employers normally purchase stop-loss insurance, which reimburses for claims that exceed a predetermined level, to limit the dollar amount of claims they will be responsible for and accordingly to protect themselves against losses from higher-than-expected claims.

Employers find self-funding attractive for a number of reasons, including lower cost and increased cash flow, control over plan design, and opportunity to opt-out of certain federal regulations, including the EHB requirement and new ACA rating standards and fees that are predicted to increase premium rates. Traditionally, self-funding has been most popular among large employers, as smaller companies cannot tolerate the risk exposure of stop-loss plans with high attachment points. In 2013, for example, 83% of covered employees in companies with two hundred or more employees enrolled in a self-funded plan compared with only 16% of covered employees in companies with three to one hundred ninety-nine employees. However, "[r]ising

87 See MERITAIN HEALTH, supra note 86 (detailing how self-funding works).
88 See PHYSICIANS CARE HEALTH PLANS, supra note 86; Lucia et al., supra note 86, at 3-4. Stop-loss insurance reimburses the employer for claims that exceed a predetermined level, known as an attachment point, and can be purchased on either a specific or an aggregate basis. See Lucia et al., supra note 86, at 3-4. Specific coverage covers catastrophic claims on one covered person whereas aggregate coverage covers catastrophic claims for the group of covered persons. See PHYSICIANS CARE HEALTH PLANS, supra note 86. If claims are lower than expected in any given year, the employer can save money, compared to paying a fully-insured set monthly premium. See id.
89 See MERITAIN HEALTH, supra note 86 (providing detailed list of self-funding benefits); Advantages and Myths of Self-Funding for Employers with Fewer Than 250 Employees, CIGNA HEALTH AND LIFE INSURANCE COMPANY 2-3, 8 (Feb. 2014), http://www.cigna.com/assets/docs/employers-and-organizations/small-business-health-insurance-plans.pdf (detailing further advantages of self-funding). Expenses are reduced in terms of administration costs, premium tax, and through elimination of insurance carrier profit margin and risk, and the employer's cash flow is improved as money that would be held by an insurance carrier is freed. MERITAIN HEALTH, supra note 86. Employers have flexibility to tailor their plan designs beyond what fully-insured carriers offer "off the shelf" and therefore can better meet the specific needs of their employees. CIGNA, supra, at 3. Finally, self-funded small employer-sponsored plans do not have to offer the ACA-mandated EHB package; are not subject to ACA rating methodologies that are based on age, tobacco use, family size, and geographic area; and are exempt from the health insurance industry fee, an annual fee that is expected to increase fully-insured premiums by 2.5% in 2014 and 3 to 4% in future years. Id. at 7-8.
90 See Lucia et al., supra note 86, at 3-4; Tracy Yee et al., Small Employers and Self-Insured Health Benefits: Too Small to Succeed?, CENTER FOR STUDYING HEALTH SYSTEM CHANGE 2 (2012), http://www.hschange.com/CONTENT/1304/1304.pdf. For example, large employers can tolerate the risk exposure of a stop-loss plan with a $60,000 or $100,000 specific attachment point much better than small employers. See Lucia et al., supra note 86, at 3-4.
91 KAISER 2013, supra note 52, at 178, 181 exhibit 10.1, 10.4 (reporting percentage of covered workers in self-funded plans, by firm size).
premiums, coupled with new regulations on fully insured products and declining costs of stop-loss insurance, could lead to an increase in self-insurance among small employers." As reported by the Henry J. Kaiser Family Foundation, while only 7% of companies with three to twenty-four employees and 1% of companies with twenty-five to forty-nine employees, definitively stated that they plan to self-insure because of the ACA, 12% and 6%, respectively, said they were undecided.

D. Federal Parity Protections Extended

Lastly, the ACA and its accompanying regulations dictate that beginning in 2014, in order to satisfy the EHB requirement, substance use disorder benefits must be provided in a manner that complies with the MHPAEA. Accordingly, the ACA applies the MHPAEA substance use disorder parity protections to the individual and small employer groups markets in the same manner and to the same extent as they apply to health insurance coverage offered in the large group employer market.

\[92\] Yee et al., supra note 90, at 3 (emphasis added) (describing advantages and attractiveness of self-funding for small employers). \(\text{See supra note 89 and accompanying text (discussing benefits of self-funded plan over fully-insured plan). A study conducted by RAND Health predicts a sizable increase in self-insurance among small employers – from 4% to 33% – if stop-loss policies with low individual attachment points, such as $20,000, become widely available after the ACA takes full effect. See Christine Eibner et al., Technical Report: Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA), RAND HEALTH, 56-58 (2011), http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf. A study by the Center for Studying Health Systems Change found that policies with low attachment points are likely to be widely available, with stop-loss attachment points as low as $10,000 were marketed in 2012. See Yee et al., supra note 90, at 3-4.}

\[93\] KAISER 2013, supra 52, at 169 exhibit 10.13 (reporting percentage of firms which plan to self-insure because of ACA, by firm size).

\[94\] See Provision of EHB, 45 C.F.R. § 156.115(a)(3) (2013). The regulation details:

Provision of EHB means that a health plan provides benefits that . . . With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under § 156.110(a)(5) of this subpart [which details the EHB], comply with the requirements of §146.136 of this subchapter [which details the MHPAEA requirements].

1. Individual Marketplace Requirement

The ACA extends the MHPAEA parity protections, originally applicable only to large group health plans, to the individual health insurance market. Thus, Americans accessing health care through non-grandfathered plans in the individual market have access to the EHB package, and are guaranteed substance use disorder coverage comparable to their general physical health coverage in terms of the following: annual and lifetime dollar limits; scope or duration of treatment limits such as frequency of treatment, number of visits, or days of coverage; and cost-sharing requirements like deductibles, copayments, or coinsurance.

2. Large Employer Group Quasi-Requirement

Since large employer group health plans are not required to provide an EHB package, the ACA does not directly mandate that these large group plans comply with the federal parity requirements. Large group plans are still subject to the federal parity requirements of the MHPAEA when they do include substance use disorder benefits in

ACA § 1311(j) (codified as amended at 42 U.S.C. § 18031(j)) (stating, under heading "Applicability of Mental Health Parity," "Section 2726 of the PHS shall apply . . ."). It also requires that substance use disorder parity protections described in section 2726 of the PHS apply to both the individual and small group markets. See ACA § 1562(c)(4) ("inserting 'or a health insurance issuer offering group or individual health insurance coverage'" in PHS § 2726); PHS § 2726 (codified as amended at 42 U.S.C. § 300gg-26) (requiring parity in substance use disorder benefits in group and individual coverage). All health insurers providing non-grandfathered, fully-insured plans in both the individual and small employer group markets are required to comply with the MHPAEA regulations to satisfy the EHB requirement. ACA § 1562(c)(4); 45 C.F.R. 156.115(a)(3); Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240-41, 68248, 68251.

Despite such re-designation and extension, the underlying parity requirements remain the same: parity between substance use disorder benefits and substantially all physical health benefits in terms of lifetime limits, annual limits, financial requirements, treatment limitations, and in- and out-of-network services and providers. Compare supra note 24 and accompanying text, with PHS § 2726 (codified as amended at 42 U.S.C. § 300gg-26(a)).

Compare supra note 27 and accompanying text (describing MHPAEA's original limited applicability to only large group health plans), with supra notes 94-95 and accompanying text (extending federal substance use disorder parity protections to individually purchased health insurance plans).

See supra notes 94-95 and accompanying text (describing MHPAEA parity protections newly applicable to individually purchased plans through EHB).

45 C.F.R § 156.115(a)(3) (detailing compliance with federal substance use disorder parity protections necessary to fulfill EHB requirement); supra note 64 and accompanying text (explaining EHB requirement applies only to individually purchased and small employer group health plans).
their health plan. In fact, available data for the years following passage of the MHPAEA and the ACA shows that large employer group health plans have implemented substantial plan design changes, making significant improvements in financial requirements and treatment limitations for substance use disorder benefits, in order to meet federal parity standards.

3. Small Employer Group Requirement

Finally, although the MHPAEA small employer exemption remains in the text, in practical application it is effectively void, as the ACA regulations require employers offering the EHB to provide substance use disorder benefits in compliance with the requirements of the MHPAEA even where such requirements would not otherwise directly apply. Thus, similar to the individual marketplace, the ACA extends the MHPAEA federal parity requirements to non-grandfathered, fully-insured health plans

99 See supra notes 24, 26 and accompanying text (requiring parity for dollar limits, visit restrictions, cost-sharing and in-network and out-of-network services).

100 See GOPLERUD, supra note 28, at 19-35, 52-54; KAISER, supra note 56, at 193 exhibit 13.7. Most large employer group health plans that did not conform to parity standards in 2009, even after implementation of the MHPAEA, modified their plans by 2011 to eliminate the more restrictive substance use disorder benefits. GOPLERUD, supra note 28, at 19-35. With respect to financial requirements, from 2009 to 2011 the percent of plans with more restrictive inpatient substance use disorder treatment benefits as compared to physical health benefits decreased, for in-network services from 6.4% to 4.0%, and for out-of-network services from 11.1% to 3.8%. Id. at 24 tbl.9. During these years, the percent of plans with more restrictive outpatient substance use disorder treatment benefits as compared to physical health benefits similarly decreased, for in-network care from 24.0% to 1.3%, and for out-of-network care from 22.3% to 7.4%. Id. at 24 tbl.10. In terms of quantitative treatment limits, from 2009 to 2011 the percent of plans that covered fewer substance use disorder inpatient days as compared to physical health inpatient days annually decreased, for in-network care from 46.2% to 8.5%, and for out-of-network care from 40.4% to 7.6%. Id. at 32 tbls.21-22. During the same period, the percent of plans that covered fewer substance use disorder outpatient days as compared to physical health inpatient days annually decreased, for in-network care from 51.1% to 8.5%, and for out-of-network care from 53.2% to 9.0%. Id. at 33 tbls.23-24. With regard to dollar limits, from 2009 to 2011 the percent of plans that applied more restrictive annual dollar limits on substance use disorder services as compared to physical health services changed as follows: for inpatient in-network care, decreased from 0.1% to 0%; for inpatient out-of-network care, remained constant at 0%; for outpatient in-network care, decreased from 9.4% to 1.0%; and for outpatient out-of-network care, decreased from 9.8% to 1.3%. Id. at 32-33 tbls.21-24. The Henry J. Kaiser Family Foundation similarly reported that in the years following passage of the MHPAEA and the ACA, 66% of large employers eliminated limits and 16% increased utilization management for substance use disorder benefits. KAISER, supra note 56, at 193 exhibit 13.

offered by small employer groups.102

III. Analysis

A. Individually Purchased Health Insurance

Even though the MHPAEA does not apply directly to individual plans, its substance use disorder parity standards apply indirectly to individual non-grandfathered plans through the ACA individual mandate and EHB package requirements.103 As such, substance use disorder parity in the individual market is nearly comprehensive, limited only by individual mandate exemptions and by the grandfathered provision of the ACA which, similar to the small group market situation, is phasing out due to market forces.104 However, nearly comprehensive is not the same as comprehensive; full substance use disorder parity in the individual market cannot be guaranteed unless and until the federal government begins to eliminate individual exemptions and definitively close the grandfathered loophole.105

102 Compare supra note 27 and accompanying text (describing MHPAEA’s original limited applicability to only large group health plans), with supra notes 94-95 and accompanying text (extending federal substance use disorder parity protections to small employer-sponsored health insurance plans), and supra text accompanying note 96-97 (detailing parity protections of MHPAEA that apply to small employer-sponsored health coverage).

103 See supra note 27 and accompanying text (explaining MHPAEA protections do not apply to plans obtained in the individual market); supra note 36 and accompanying text (describing ACA individual mandate); supra notes 64, 66 and accompanying text (describing ACA EHB requirement that applies to non-exempt and non-grandfathered individually purchased health plans); supra notes 94-95 and text accompanying notes 96-97 (EHB requires that individually purchased health plans provide MHPAEA compliant substance use disorder coverage parity).

104 See supra notes 43-47 and accompanying text (detailing various exemptions to individual mandate); supra notes 66-73 and accompanying text (explaining grandfathered loophole in individual market, its EHB relevance, and its predicted phasing out).

105 See supra notes 43-47, 66-73 and accompanying text (describing certain individual exemptions and grandfathered loophole as barriers to achieving substance use disorder parity). Americans exempt from the individual mandate are not required to maintain minimum essential health coverage and, therefore, are likely either to not have access to substance use disorder benefits, or to not have access to substance use disorder benefits that are equal, in terms of financial requirements and treatment limitations, to physical health benefits. See supra notes 43-47 and accompanying text (listing categories of individuals exempt from maintaining coverage and detailing consequences of such exemption). Similarly, Americans maintaining individually purchased grandfathered health coverage may not have access to either substance use disorder benefits, or not have access to substance use disorder benefits that are equal, in terms of financial requirements and treatment limitations, to physical health benefits. See supra notes 66-73 and accompanying text (describing grandfathered health plans and consequences of grandfathered substance use disorder parity loophole).
1. Individual Mandate – A Need to Reduce Exemptions

Although the CBO estimates that only 7% of the American population will be exempt from the ACA individual mandate and penalty via the numerous mandate exemptions, twenty-four million individuals summates to no small number.\(^{106}\) Moreover, this figure has potential to grow should the Obama Administration continue to increase the number of wide-ranging individual mandate exemptions.\(^{107}\) Such action would not be uncommon for the Obama Administration which, in the name of "affordable health insurance coverage," has delayed implementation of countless ACA provisions, and expanded the hardship exemption in December 2013 to include individuals whose policies are canceled and who believe their alternative coverage options are more expensive.\(^{108}\)

To achieve full substance use disorder parity, rather than continue to add or even remain at status quo, the federal government must reduce the number of individual mandate exemptions available under the ACA.\(^{109}\) Until such action is taken, millions of Americans will not be required to obtain ACA-compliant health insurance coverage, and therefore, will lack guaranteed access to substance use disorder benefits that are no more restrictive than physical health benefits.\(^{110}\)

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\(^{106}\) See supra notes 46-47 and accompanying text (accounting twenty-four million Americans, or 7% of population, will be exempt from ACA individual mandate). This may be a relatively small number; however, this is nearly the population of Texas, the second most populous state in the United States, and therefore is not, in absolute terms, a small number. See U.S. and World Population Clock, supra note 47 (listing Texas' population as 26,448,193).

\(^{107}\) See supra text accompanying notes 43-45 (discussing individual exemptions currently in place); supra text accompanying notes 46-47 (detailing percentage projection of Americans exempt from ACA's individual mandate given current exemptions).

\(^{108}\) See supra notes 43-46 and accompanying text (describing ACA individual mandate exemptions as of 2014 and number of Americans exempt); OPTIONS AVAILABLE FOR CONSUMERS WITH CANCELLED POLICIES, supra note 45 (noting President Obama's announcement of hardship exemption from individual mandate in 2013); supra notes 48-50 (discussing postponement of employer shared responsibility provision, first to 2015, and later to 2016).

\(^{109}\) See supra text accompanying notes 36-37, 43-47 (explaining ACA individual mandate, listing exemptions, and predicting number of Americans exempt). Fewer individual mandate exemptions will mean that more Americans will be required to maintain minimum essential health coverage, and therefore, more likely to gain access to substance use disorder benefits or to gain access to substance use disorder benefits that are equal, in terms of financial requirements and treatment limitations, to physical health benefits. See supra 96-97 and accompanying text (explaining plans obtained through individual marketplace subject to EHB and MHPAEA requirements).

\(^{110}\) See supra notes 46-47 and accompanying text (estimating twenty-four million Americans exempt from ACA individual mandate); discussion supra note 105 (explaining exempt individuals lack access to coverage and therefore access to substance use disorder parity).
2. Grandfathered Health Plans — A Need to Close the Loophole

Available data suggests that many individually purchased grandfathered health plans are losing, and in coming years will continue to lose, their privileged, EHB-exempt status, both as insurance carriers cancel such plans and as individuals voluntarily switch to new health insurance plans that do not enjoy grandfathered status. As market forces, insurers and policyholders continue to eliminate such grandfathered plans, and given the individual mandate, presumably more Americans will shop and renew on the regulated health insurance exchanges; hence, a greater percentage of the population will benefit from the EHB requirement which guarantees access to substance use disorder coverage equal to coverage provided for physical health benefits. In this way, the ACA individual mandate, EHB requirement, and EHB-incorporated MHPAEA provisions will prove instrumental in coming years to increasing substance use disorder parity in the individual health insurance marketplace.

Termination of individually purchased grandfathered health plans is a decision left entirely to health insurance carriers and to individual consumers. So, should carriers decide not to cancel grandfathered health plans or should individuals decide not to switch to non-grandfathered health plans, millions of Americans will be able to remain on their old health plans, many of which do not provide for substance use disorder parity benefits. Although the data suggests the majority of grandfathered

111 See supra text accompanying notes 71-73 (predicting percent of plans that will lose grandfathered status).
112 See supra text accompanying notes 36-37 (explaining individual mandate); supra text accompanying note 66 (explaining all non-grandfathered individually purchased plans must incorporate EHB); supra text accompanying notes 94-95 (explaining satisfaction of EHB requires compliance with MHPAEA parity protections); supra text accompanying notes 96-97 (explaining applicable MHPAEA parity protections). Fewer grandfathered health plans will mean more Americans will be required to purchase health plans that comply with the EHB requirements resulting in substance use disorder benefits that are equal, in terms of financial requirements and treatment limitations, to physical health benefits. See supra text accompanying notes 36-37, 66, 94-97.
113 See supra text accompanying notes 36-37, 66, 94-97 (explaining individual mandate, EHB requirement, and incorporated MHPAEA protections applicable to non-grandfathered individual health plans).
114 See supra notes 69-70 and accompanying text (explaining insurers may decide to terminate or renew grandfathered health plans); supra text accompanying note 73 (explaining individual policyholders may decide to terminate or renew grandfathered health plans). Although insurance companies and individuals must comply with certain requirements to retain grandfathered status, if such requirements are met, insurance companies may continue to offer, and individual Americans may continue to be covered, under grandfathered health plans. See supra notes 69-70 and accompanying text; supra text accompanying note 73.
115 See supra notes 69-70, 73 and accompanying text (describing option to continue grandfathered
plans are scheduled to terminate, and although once grandfathered status is relinquished it cannot be regained, it is still important to note that market forces and not strategic government action will be the cause of greater substance use disorder parity in the individual marketplace.116

B. Large Employer Group Plans – A Need to Extend the EHB Requirements

The enactment of the ACA has left substance use disorder parity rules for group plans with more than fifty employees largely unchanged.117 Post-ACA, large employer substance-use disorder parity rules are as follows: (1) whether fully- or self-insured and whether grandfathered or non-grandfathered, such group plans are required to offer health care coverage to their employees; (2) such plans do not have to include substance use disorder coverage; (3) if such plans offer substance use disorder coverage, it can be no more restrictive than the coverage provided for physical health benefits.118 Thus, while short of ensuring comprehensive substance use disorder parity, in comparison to small employer group plans, the intersection of the MHPAEA and the ACA with respect to large employer group plans is far more seamless and leaves fewer

health plans); supra notes 66, 94-95 and accompanying text (explaining only non-grandfathered, and not grandfathered, plans must comply with EHB and associated MHPAEA requirements).

116 See supra notes 67, 69 and accompanying text (describing technicalities of enrolling in and maintaining grandfathered health coverage); supra notes 72-73 and accompanying text (suggesting grandfathered plans are being eliminated); supra text accompanying notes 69-70, 73 (explaining elimination up to insurers and individuals, not government; describing substance use disorder parity consequences).

117 Compare supra notes 24, 27 and accompanying text (describing pre-ACA substance use disorder parity rules applied to large employers), with supra notes 48-51, 74, 98-99 and accompanying text (describing post-ACA substance use disorder parity rules applied to large employers). The main difference between the pre- and post-ACA substance use disorder parity rules is that only the ACA, and not the MHPAEA, requires that all large employers offer health care coverage to their employees. See supra notes 48-51 and accompanying text (describing newly mandated ACA large employer shared responsibility provision). However, under both the MHPAEA and the ACA, large employer group health plans do not have to include substance use disorder benefits in their offer of health care coverage; the reasoning being that, for the MHPAEA, the law is not a parity mandate, and for the ACA, large employers are exempted from the EHB package requirement. Compare supra note 26 and accompanying text (explaining MHPAEA is not a parity mandate), with supra note 74 and accompanying text (explaining ACA EHB requirement does not apply to large employers). Finally, both pre- and post-ACA, the MHPAEA dictates that if a large employer group plan offers substance use disorder benefits, such coverage must be at least equal to the coverage offered for physical health benefits in terms of treatment limitations and financial requirements. See supra notes 24, 26, 99 and accompanying text.

118 See supra notes 48-51, 74, 98-99 and accompanying text (detailing ACA provisions that constitute substance use disorder parity law that applies to large employers).
loopholes to be exploited. Moreover, substance use disorder benefits made available to Americans through their large employers have been a boon to the federal parity effort. A sense of caution remains as large employers have made substance use disorder benefits available to their employees mainly through their own decisions. Should such employers decide to terminate substance use disorder benefits from their health insurance plans, nothing would prevent these plans from doing so because neither the MHPAEA nor the ACA require large employers to make substance use disorder benefits available to their employees.

Forthcoming changes under the ACA, such as "small employer" redefined in 2016 to include businesses employing up to one hundred employees and HHS-approved state exchanges opening up to employers with one hundred or more employees in 2017,
are potentially promising steps. Still, the actual effects of changes remain to be seen; while such changes may increase the pool of employers to which the ACA substance use disorder parity provisions apply, they fall short of bringing large employers under the substance use disorder parity rule of the ACA.

In actual fact, the only way to ensure large employers continue to make substance use disorder benefits available to their employees in the future and therefore to solidify comprehensive substance use disorder parity in the large employer group market, is to extend and apply the ACA EHB package requirements to employers with more than fifty employees. Such a mandate would guarantee that all large employers, required under the ACA to offer health insurance coverage to their employees, include substance use disorder benefits in such offering, and that such substance use disorder benefits are equal, in terms of treatment limitations and financial requirements, to all large employer plans and will presumably be subject to the EHB and associated MHPAEA rules. See ACA § 1304(b) (codified as amended at 42 U.S.C. § 18024) (redefining small employer to include business with up to 100 employees); supra text accompanying notes 77-78 (noting EHB requirement generally applies to small employer group market); supra text accompanying notes 94-95 (explaining satisfaction of EHB requires compliance with MHPAEA parity protections); supra text accompanying notes 96-97 (explaining applicable MHPAEA parity protections). However, the small employer group market has its own shortcomings and many more loopholes than the large employer group market. See infra Part III.C (describing substance use disorder parity issues in small group market). Also, exchanges opened up to large employers may be a positive thing because should these plans, in order to be competitive and attract more consumers, decide to enter the exchanges, they will be required to incorporate an EHB package. See ACA § 1301(a); Glossary: Qualified Health Plan, supra note 37 (explaining plans sold on exchanges must comply with EHB requirement).

If the EHB requirement is extended to large employers, such employers will be required both to offer substance use disorder coverage and to offer it on an equal basis with physical health benefits. See supra notes 48-51 and accompanying text (describing requirement that large employer plans offer coverage to employees); supra notes 64-65 and accompanying text (describing EHB that would be part of large employer plan and provide for substance use disorder coverage); supra note 94 and accompanying text (describing satisfaction of EHB requires compliance with MHPAEA parity protections).
other physical health benefits offered. Then, full substance use disorder parity in the large employer group market will be attained.

Truly, unless such definitive action is taken to extend the EHB requirement to the large employer group market, the fate of the substance use disorder parity effort in this large group market will continue to rest on the whims of large employers reacting to market changes.

C. Small Employer Group Plans

With regard to small group employers, if such companies offer a non-grandfathered and fully insured plan, such plan must incorporate an EHB package that complies with the requirements of the MHPAEA. In this way, many plans previously exempt from the MHPAEA parity protections are now required to offer coverage for substance use disorder that is equal to the coverage provided for physical health benefits. However, the number of people that will in reality gain access to such equal substance use disorder coverage through small group employer plans may be limited by one or more of a number of factors.

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126 See supra notes 48-51, 64-65, 94 and accompanying text (providing, if all applied to large employer group market, comprehensive substance use disorder parity).

127 See supra note 5 and accompanying text (defining substance use disorder parity).

128 See supra notes 121-122 and accompanying text (explaining substance use disorder benefits are optional for and terminable by large employers). Should market conditions change and make offering substance use disorder benefits to employees less profitable or appealing for large employers, these employers are free, under the current law, to terminate the offering of these substance use disorder benefits. See supra notes 121-122 and accompanying text.

129 See supra notes 53, 64-65, 77-78, 101-102 and accompanying text (providing substance use disorder parity requirement with respect to small employers offering non-grandfathered, fully-insured plans).

130 See supra notes 101-102 and accompanying text (explaining ACA extends MHPAEA federal parity requirements to small employer non-grandfathered, fully-insured health plans). Many small group health plans that were previously exempt from the MHPA and the MHPAEA are prohibited, under the ACA, from including substance use disorder benefits that are more restrictive than benefits offered for physical health in terms of financial requirements and treatment limitations. See supra note 101 (providing small employer exception, though still in text, irrelevant and ineffective by ACA in reality).

131 See infra Parts III.C.i-III.C.iii (detailing employer shared responsibility exemption, and grandfathered and self-funding loopholes threaten substance use disorder parity).
1. Exempt from Offering Coverage – A Need to Extend the Employer Shared Responsibility Provision

First, small employers are not required to offer any health coverage.132 Although many small employer groups do offer coverage to their employees, the data suggest that Americans want or need health insurance at rates greater than it is being offered.133 Because their employers cannot always afford to offer health insurance coverage, many Americans must turn to the individual market.134 Dependence on the individual market may prove to be a positive thing, as a majority of individually purchased plans are subject to the EHB package and accompanying federal parity protections.135 However, individual coverage may be more expensive for consumers who lack both the benefit of employer premium contribution and the pre-tax benefits of a Section 125 Premium Only Plan in this market.136 Ultimately, this may lead to individuals claiming the plan unaffordable and subsequent application of individual mandate exemptions that have the potential to undermine substance use disorder parity.137 Moreover, an exodus to the individual marketplace does not solve the small employer group market substance use disorder parity problem.138

If full substance use disorder parity is to be guaranteed in the small employer group market, the decision to offer health insurance coverage cannot be left to small employers, but rather, the federal government must extend the employer shared responsibility provision, currently applicable to large group employers, to small group

132 See supra note 53 and accompanying text (explaining small employers are exempt from shared responsibility provision).
133 See supra text accompanying notes 60-63 (documenting small employer health care offering and participation percentages 2010 through 2013).
135 See supra Parts II.A.i, II.B.i, II.C.i (describing individual mandate, EHB, and MHPAEA protections collectively apply substance use disorder parity to individual market).
136 See supra note 40-42 and accompanying text (explaining Premium Only Plan benefits cannot be accessed in connection with individually purchased health insurance).
137 See supra notes 43, 45 and accompanying text (describing various individual mandate exemptions, including unaffordability and hardship); supra notes 106 - 107 and accompanying text (explaining how individual mandate exemptions are an obstacle to achieving full substance use disorder parity).
138 See infra notes 139-140 and accompanying text (arguing employer shared responsibility provision must be extended to small employer group market).
employers. The result of such action would be for all small group eligible employees to have access to health insurance coverage that, via the EHB package, includes substance use disorder benefits that are equal in terms of financial requirements and treatment limitations to physical health benefits.\textsuperscript{139}

2. Grandfathered Health Plans – A Self-Correcting Problem

The grandfathered provision of the ACA has potential negative consequences with respect to comprehensive parity for substance use disorder coverage as small employers who offer a grandfathered plan are not bound by the EHB package rules of the ACA.\textsuperscript{140} Such employers, therefore, do not have to include coverage for substance use disorder benefits, nor do they have to provide for parity of such benefits if they are included.\textsuperscript{142} Nonetheless, adverse effects are likely to be short-term and grandfathered plans may not pose as serious long-term threats to substance use disorder parity in the small group market as originally anticipated.\textsuperscript{143}

\textsuperscript{139}See supra note 53 and accompanying text (explaining small group employers do not have to provide coverage to employees); supra text accompanying notes 59-62 (detailing decreases in small employer health insurance offerings despite employee interest); supra text accompanying notes 77, 101-102 (describing EHB and MHPAEA requirements applicable to small employer insurers offering coverage). Under current law, substance use disorder parity in the small employer group market is limited as employers are not required to offer coverage and therefore are not required to provide substance use disorder benefits to their employers that are equal, in terms of financial requirements and treatment limitations, to physical health benefits. See supra note 53; supra notes 59-62, 77, 101-102 and accompanying text (detailing substance use disorder parity in small group market only if employers offer health coverage).

\textsuperscript{140}See supra notes 77, 101-102 and accompanying text (describing EHB and incorporated MHPAEA requirements that would apply to all small group eligible employees).

\textsuperscript{141}See supra notes 77, 101-102 and accompanying text (noting grandfathered plans are exempt from EHB and incorporated MHPAEA requirements).

\textsuperscript{142}See supra notes 77, 101-102 and accompanying text (noting grandfathered plans are exempt from EHB and incorporated MHPAEA requirements).

\textsuperscript{143}Compare Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 1251(a), (e) (March 23, 2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010) (codified as amended in scattered sections of 26, 42 U.S.C. (2013)) (merely providing for grandfathered provision), with supra note 79 (listing ways in which grandfathered status can be lost, as detailed in ACA regulations). The ACA regulations include rules not included in the ACA as originally enacted. Compare ACA § 1251(a), (e) (codified as amended at 42 U.S.C.A. §§ 18011(a), (e)), with supra note 79 (detailing ACA regulations). The ACA is silent on how much a plan can change over time and still be regarded as grandfathered. See ACA § 1251(a), (e) (codified as amended at 42 U.S.C.A. §§ 18011(a), (e)). “The administration chose a middle ground, recognizing that health plans typically have moveable parts—premiums, deductibles, copayments, benefits packages—and that it was unrealistic to expect an existing plan to remain completely frozen in time forever.” Merlis, supra note 79, at 2. However, despite the leeway they do still have to make changes to their grandfathered plans, small employers are forfeiting their privileged grandfathered status. See supra text accompanying notes 80-84.
In general, over the next few years, section 1251 of the ACA, the grandfathered provision, is unlikely to significantly hinder the effort towards substance use disorder parity.\textsuperscript{144} Though grandfathered plans still exist in the small group market, many employers have, and continue to, replace such plans with ACA-compliant plans which allow for more flexibility in employer cost control measures.\textsuperscript{145} In effect, the rate at which small group employer health plans forfeit grandfathered status will likely advance substance use disorder parity, as more plans will be required to include the EHB package and more Americans will therefore have access to the associated parity protections of the MHPAEA.\textsuperscript{146} Noteworthy is the fact that this outcome would serve as a product of employer choice motivated by market forces, not of government action.\textsuperscript{147}

3. Self-Funded Plans – A Potentially Large Loophole that Needs Closing

Finally, the small employer self-funded loophole threatens substance use disorder parity in the small employer group market because federal law exempts such plans from the EHB and incorporated MHPAEA requirements of the ACA.\textsuperscript{148} Although self-funding has not been popular among small employers in the past, available data suggests that it may become more amenable to, and more common among, small employers in the near future.\textsuperscript{149} Should such a situation materialize, the substance use disorder parity effort in the small employer group market will wane.\textsuperscript{150} Again, the only way to protect against a decline in the substance use disorder parity effort and to guarantee full substance use disorder parity in the small employer group market is through government action; the federal government must eliminate the small

\textsuperscript{144} See supra notes 78-80 and accompanying text (explaining why small employer group health plans forfeit grandfathered status); supra notes 82-84 and accompanying text (detailing percent of small employer group health plans forfeiting grandfathered status 2011 to 2013).

\textsuperscript{145} See supra notes 82-84 and accompanying text (detailing percent of small employer group health plans forfeiting grandfathered status 2011 to 2013).

\textsuperscript{146} See supra notes 77, 101-102 and accompanying text (describing EHB and incorporated MHPAEA requirements that apply to non-grandfathered small employer-sponsored health plans).

\textsuperscript{147} See supra note 77 (noting grandfathered provision of the ACA remains in place).

\textsuperscript{148} See supra notes 77-78, 85, 101-102 and accompanying text (explaining small employer self-funded plans are exempt from EHB and incorporated MHPAEA requirements).

\textsuperscript{149} See supra notes 89-93 and accompanying text (explaining benefits, new compatibility and prevalence of self-funding with respect to small employer groups).

\textsuperscript{150} See supra note 148 and accompanying text. If more small employers self-fund, fewer small employers will be subject to the EHB and MHPAEA requirements. See supra note 148 and accompanying text (explaining small self-funded plans, exempt from EHB and MHPAEA, can provide substance use disorder disparity).
employer self-funded loophole.151

IV. Conclusion

Since the federal benefit parity effort began in the 1990s, parity protections for substance use disorder coverage have extended and strengthened substantially. Legislative efforts culminating in the MHPA, MHPAEKA and the ACA have been instrumental in ensuring that a greater number of Americans has access to coverage for substance use benefits that is equal to coverage for physical health benefits in terms of financial requirements and treatment limitations including dollar limits, cost-sharing features, and visit restrictions. However, although each law has built upon the last, reinforcing well-merited policies and implementing new rules to rectify outstanding shortcomings, full parity has yet to be attained. Tellingly, the ACA and MHPAEKA are not directly related but co-exist, each with their own exemptions, thus providing ripe opportunity for the exploitation of newly-created gaps and unresolved deficiencies between the two.

Some exemptions and loopholes, such as the small employer and individually purchased grandfathered health plans and large employer health plans exemptions from EHB and MHPAEKA, appear self-correcting. That is, market forces and the choices of individual Americans, insurance companies, and employers may render them irrelevant. Should market conditions change or should any pertinent segment of the American population make different healthcare coverage offerings, purchasing or renewing decisions, full substance use disorder parity will be at risk. Moreover, some exemptions and loopholes, such as self-funded plans exempt from EHB and MHPAEKA requirements and increasing numbers of individual mandate exemptions, pose serious threat to substance use disorder parity.

The fate of the effort towards full substance use disorder parity in the private health insurance market hinges upon the extent to which Americans – individual policyholders, employers and employees, and health insurance companies – will take advantage of existing exemptions and loopholes. The only way to protect against widespread exploitation is to remove, via federal law, the possibility of substance use disorder disparity. The federal government must take further action; it must eliminate exemptions and close loopholes if full substance use disorder parity is to be realized in the United States private health insurance market.

151 See supra notes 77, 101-102 and accompanying text (describing EHB and MHPAEKA requirements that would apply to small employer-sponsored self-funded plans).