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SUBSTANCE USE DISORDER INSURANCE BENEFITS: A SURVEY OF STATE BENCHMARK PLANS

STACEY A. TOVINO[†]

“Thank you so much for the generous introduction and thank you for the opportunity to be here today. I am so impressed by the incredible Health Law Program that Dr. Kelly Dineen has built in such a short amount of time¹ and it is an honor for me to be able to participate in this symposium. Thank you again for the opportunity to be here.

I was so excited when I learned that the focus of this symposium was ‘Inequities and Injustice in Health Care’ because a good portion of my scholarly work has focused on inequities and injustices in the context of health insurance.² In my time today, I would like to present the results of my latest research project—a survey of state benchmark health plan coverage of substance use disorder treatments and services, including treatments and services for opioid use disorder.³ As I will explain, mental health insurance inequities and injustices re-

[†] Judge Jack and Lulu Lehman Professor of Law, William S. Boyd School of Law, University of Nevada, Las Vegas. I thank the organizers and participants of the “Inequities and Injustices in Health Care” Symposium at Creighton University School of Law for their comments on the ideas presented in this article. I also thank the Creighton Law Review for the opportunity to participate in this symposium.

1. Creighton University School of Law, Academics, JD Concentration, Health Law, Meet the Director: Kelly Dineen, RN, JD, PhD, at <https://law.creighton.edu/academics/jd-concentrations/health-law/meet-director> (noting that Creighton University School of Law hired Dr. Dineen to build out the School of Law’s Health Law Program and that Dr. Dineen joined the faculty in 2017).

2. The Author has reviewed the history of mental health insurance disparities in a number of prior articles addressing the legal rights of individuals with gambling disorder and other mental health conditions. See e.g., Stacey A. Tovino, *Problem Gambling and the Business Lawyer*, in *WHAT EVERY BUSINESS LAWYER NEEDS TO KNOW ABOUT GAMING LAW* (Keith Miller ed., forthcoming 2019); Stacey A. Tovino, *A Right to Care*, 70 ALABAMA L. REV. 183 (2018); Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TULANE L. REV. 191 (2014); Stacey A. Tovino, *Dying Fast: Suicide in Individuals with Gambling Disorder*, 10 ST. LOUIS U. J. HEALTH L. & POL’Y 159 (2016) (invited symposium); Stacey A. Tovino, *Gambling Disorder, Vulnerability, and the Law: Mapping the Field*, 16 HOUS. J. HEALTH L. & POL’Y 102 (2016) (invited symposium). The overview of mental health parity law and mandated mental health and substance use disorder benefit law in these remarks are taken with permission, and with several recent updates as well as technical and conforming changes, from these and the Author’s other prior works in this area.

3. Stacey A. Tovino, *State Benchmark Plan Coverage of Opioid Use Disorder Treatments and Services: Trends and Limitations*, S.C. L. REV. (forthcoming 2019) (surveying state benchmark health plan coverage of substance use disorder benefits with a focus on opioid use disorder benefits).

main, even after the implementation of President Obama's Affordable Care Act ("ACA"), and these inequities and injustices could get worse in the near future if the December 14, 2018, opinion of the United States District Court for the Northern District of Texas striking down the entire ACA⁴ is affirmed by the United States Court of Appeals for the Fifth Circuit and/or the U.S. Supreme Court, as appropriate.

Before I present my survey results, let me provide some background information regarding mental health insurance benefit disparities in the United States. Historically, both public health care programs, including Medicare and Medicaid, as well as private health insurers distinguished between physical and mental disorders and provided inferior insurance benefits to individuals with conditions that could be classified as mental, such as major depression, bipolar disorder, schizophrenia, alcohol use disorder, and the substance use disorders, as compared to conditions traditionally classified as physical, such as cancer, a broken arm, or high blood pressure.⁵ Examples of these mental health insurance benefit disparities included the refusal by some health plans to cover any treatments or services provided for anyone who could be considered to have a mental, emotional, psychiatric, psychological, nervous, or similar condition, such as major depression, bipolar disorder, schizophrenia, alcohol use disorder, or one of the substance use disorders.⁶

Even when health plans voluntarily covered mental health and substance use disorder services, there were still noticeable injustices and inequities. Historically, they tended to impose lower lifetime and annual spending limits, lower numbers of covered inpatient days, lower numbers of covered outpatient visits, higher deductibles, higher copayments, higher coinsurance amounts, more stringent medical necessity requirements, most frequently applied prior authorization requirements, and more stringent experimental or investigative exclusions on those offered mental health benefits.⁷

Just so you can see an example of what these exclusions actually look like, this slide shows provisions set forth within an older health plan issued in a midwest market that excludes coverage of all substance use disorder treatments, some alcohol use disorder treatments,

4. *Texas v. United States*, 340 F. Supp.3d 579, 615 (D.N.D. Tex. 2018) ("In sum, the Individual Mandate 'is so interwoven with [the ACA's] regulations that they cannot be separated. None of them can stand.'") (internal citations omitted); *id.* at 585 (declaring the ACA's individual mandate unconstitutional and further declaring the remaining provisions of the ACA "inseverable" and therefore "invalid").

5. *Tovino, Problem Gambling and the Business Lawyer*, *supra* note 2, at Part I (reviewing the history of mental health insurance benefit disparities in the United States).

6. *Id.*

7. *Id.*

and some residential treatments of the type frequently used by individuals with substance use disorders.⁸ This next slide shows provisions set forth within a health plan issued in a northeast market that contains a wide variety of behavioral health exclusions.⁹

During the past twenty-five years, mental health parity advocates have been trying to chip away at these mental health benefit disparities one by one.¹⁰ Even today, they are not gone and they soon may be getting worse all over again. That said, in 1996, President Clinton signed the original Mental Health Parity Act (“MHPA”) into law.¹¹ As originally enacted, MHPA prohibited large employer group health plans that offered physical and mental health benefits from imposing more stringent lifetime and annual spending limits on their offered mental health benefits.¹² For example, MHPA would have prohibited a covered large group health plan from imposing a \$5,000 annual cap or a \$50,000 lifetime cap on mental health care if the plan had no annual or lifetime caps for medical and surgical care or if the plan had higher caps for physical health care.¹³

Although President Clinton is usually applauded for this first federal step towards mental health parity, the application and scope of MHPA were very limited. As originally enacted, MHPA regulated only group health plans of large employers, then defined as those employers that employed an average of fifty-one or more employees.¹⁴ MHPA did not apply to the group health plans of small employers. MHPA also did not apply to individual health plans, Medicaid non-managed care plans, or any self-funded, nonfederal governmental plan whose sponsor opted out of MHPA.¹⁵ In addition, individuals with substance use and addictive disorders, including opioid use disorder, which is

8. Stacey A. Tovino, PowerPoint, Substance Use Disorder Benefits: A Survey of State Benchmark Plans, at Slide 3, presented at Creighton University School of Law, Creighton Law Review Symposium, Mar. 7, 2019 [hereinafter *Tovino PowerPoint*].

9. *Id.* at Slide 4.

10. Tovino, *Problem Gambling and the Business Lawyer*, *supra* note 2, at Part I (summarizing federal efforts to eliminate mental health insurance benefit disparities).

11. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)) [hereinafter *MHPA*].

12. *Id.*

13. *Id.*

14. *Id.* § 712(c)(1)(A)–(B) (applying in each case to “a group health plan (or health insurance coverage offered in connection with such a plan)”); *id.* (exempting from the MHPA application group health plans of small employers; defining small employers as those “who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year”).

15. *See, e.g.*, 42 U.S.C. § 300gg-21(a)(2)(A) (2012) (statutory provision permitting sponsors of self-insured nonfederal governmental health plans to opt out of particular federal requirements); 45 C.F.R. § 146.180(a)(1)(v) (2015) (regulatory provision doing the same).

what I am specifically interested in, were specifically excluded from MHPA's modest lifetime and annual spending cap protections.¹⁶ So there were two tiers of patients with mental health conditions; those with protected conditions, such as major depression, and then the less deserving; that is, those with addiction.¹⁷ Moreover, MHPA did not require parity in any other context other than annual and lifetime limits; that is, MHPA did not require parity between physical and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations.¹⁸

Finally, MHPA was also neither a mandated offer nor a mandated benefit law. Nothing in MHPA required a covered group health plan to actually offer or provide any health insurance benefits for individuals with mental health conditions.¹⁹ In my prior career, I would advise my client insurers not to offer any mental health benefits because, if they did, MHPA required them to make their offered mental health benefits equal to their offered physical health benefits in the context of lifetime and annual spending limits. You can probably see that my old job made me uncomfortable, which is now why I have a very different career.

Perhaps because of MHPA's limitations, President George W. Bush signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").²⁰ MHPAEA built on MHPA by expressly protecting individuals with substance-related and addictive disorders, including opioid use disorder, and by imposing comprehensive parity requirements on large group health plans.²¹

In particular, MHPAEA provided that any financial requirements (including deductibles, copayments, coinsurance, and other out-of-pocket expenses) as well as any treatment limitations (including inpatient day and outpatient visit limitations as well as non-quantitative

16. MHPA, *supra* note 11, § 712(e)(4) ("The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.").

17. *Id.*

18. *Id.* § 712.

19. *Id.* § 712(b)(2) ("Nothing in this Section shall be construed . . . as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage.").

20. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (codified as amended at 26 U.S.C. § 9812 (2012); 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)) [hereinafter MHPAEA].

21. *Id.* § 512(a)(4) (adding a new definition of "substance use disorder benefits"); *see also id.* § 512(a)(1) (regulating the financial requirements and treatment limitations that are applied to both mental health and substance use disorder benefits).

treatment limitations such as prior authorization requirements) that large group health plans imposed on mental health and substance use disorder benefits could not be any more restrictive than the predominant financial requirements and treatment limitations imposed by the plan on substantially all physical health benefits.²² MHPAEA thus would have prohibited a large group health plan from imposing higher deductibles, copayments, or coinsurance amounts, or lower inpatient day or outpatient visit maximums, or more frequently applied prior authorization requirements on mental health conditions compared to physical health conditions.²³ Like MHPA, however, MHPAEA only regulated large group health plans.²⁴ MHPAEA also was not a mandated benefit law, so a covered health plan could refuse to offer any mental health or substance use disorder benefits and remain in compliance with MHPAEA.²⁵

Two years later, in 2010, President Obama responded to this limitation by signing into law the Affordable Care Act (“ACA”).²⁶ Now, this is where it gets interesting really quickly, because everything I am about to say after this point about the ACA could go away if the U.S. Court of Appeals for the Fifth Circuit or the U.S. Supreme Court affirm the December 14, 2018, federal district court opinion of the Northern District of Texas striking down the entire Affordable Care Act.²⁷

That said, one set of relevant ACA provisions that you see on these two slides here and here extended MHPA’s and MHPAEA’s mental health parity provisions to the individual and small group health plans offered on and off the ACA-created health insurance ex-

22. *Id.* § 512(a)(1).

23. *Id.*

24. *See, e.g.*, 42 U.S.C. § 300gg-26 (2012) (stating that the MHPAEA applies only to “group health plan[s] or (health insurance coverage offered in connection with such plan[s])”); Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 *MILBANK Q.* 404, 407 (2010) (explaining that MHPAEA applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care, the State Children’s Health Insurance Program, and state and local government plans, but not Medicaid non-managed care plans); *SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., APPROACHES IN IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)* (noting that “[s]elf-insured non-federal government employee plans can opt out of the federal parity law” and that the MHPAEA’s requirements do not apply to “[s]mall employer plans created before March 23, 2010,” “[c]hurch-sponsored plans and self-insured plans sponsored by state and local governments,” “[r]etiree-only plans,” TriCare, Medicare, and “[t]raditional Medicaid (fee-for-service, non-managed care)”).

25. MHPAEA, *supra* note 20, § 512(a)(1) (regulating only those group health plans that offer both physical health and mental health benefits).

26. Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.) [hereinafter ACA].

27. *Texas v. United States*, 340 F. Supp.3d 579 (N.D. Tex. 2018).

changes.²⁸ The reason this is relevant to the topic of this symposium is that many individuals who could not otherwise afford health insurance were encouraged by the ACA's individual health insurance mandate and premium tax credits to purchase a qualified health plan.²⁹ Once purchased, federal mental health parity law protected the purchasers. However, the ACA's extension of mental health parity to qualified health plan purchasers will be undone if the entire ACA is found to be unconstitutional.³⁰ In that case, these individuals would likely revert back to mental health insurance benefit disparities. I am uncomfortable with this potential result because it adversely impacts individuals with low resources who struggle with mental health and substance use disorders.

A second set of relevant ACA provisions required individual and small group health plans offered on and off the exchanges as well as certain other plans to actually offer mental health and substance use disorder services in addition to nine other categories of essential health benefits ("EHBs").³¹ The catch is that the statutory EHB requirement was vague as to exactly which benefits had to be provided. For example, note that the EHB provision that you see on this slide does not say that if you have opioid use disorder, your insurance must cover detoxification services, medication-assisted treatment, or a dose of take-home naloxone.³² For those of us who teach health law, we always say that federal health statutes are notoriously vague, and this statutory EHB provision is no exception.

What the federal government did to implement this EHB provision is require states to select a benchmark plan that provided coverage for the ten EHB categories, including mental health and substance use disorder services.³³ The ACA then required EHB-regulated plans in the state to provide health benefits that are "substantially equal" to those provided by the state's benchmark plan, including both covered and excluded benefits.³⁴ Since the initial benchmark plan selection process, states have had two additional op-

28. Tovino PowerPoint, *supra* note 8, at Slides 13-14.

29. ACA § 1401 (establishing a refundable tax credit providing premium assistance to individuals who purchase qualified health plan coverage).

30. *See Texas*, 340 F. Supp.3d at 613-15 (discussing the inseparability of the individual mandate with the rest of the ACA's provisions).

31. ACA § 1302(b)(1) (establishing the ten EHBs).

32. *See id.* § 1302(b)(1)(E) (requiring the provision of mental health and substance use disorder services, including behavioral health treatments).

33. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,866 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, and 156) (adopting 45 C.F.R. § 156.100) [hereinafter First Benchmark Plan Regulations].

34. 45 C.F.R. § 156.115(a)(1) (2018).

portunities to select benchmark plans.³⁵ The most recent opportunity was in 2018, when states had the opportunity to select a third benchmark plan that would go into effect in 2020.³⁶ I think states got tired of picking new benchmark plans after the second go around because all states except for Illinois kept their second benchmark plan.

In my latest research project, I surveyed the most recently selected benchmark plans of all fifty states and the District of Columbia.³⁷ What I found is that: (1) these benchmark plans demonstrate substantial variation in terms of their substance use disorder coverage and limitations provisions; (2) some state benchmark plans continue to impose coverage restrictions on substance use disorder care that are not imposed on physical health care; and (3) some state benchmark plans have gone out of their way to help out individuals with substance use disorders in general and opioid use disorder in particular.

The first state benchmark plan I want to show you is that of Illinois, because Illinois is the only state to have taken advantage of the opportunity to select a third benchmark plan and the only state whose benchmark plan appears to be specifically designed to respond to the opioid crisis.³⁸ Illinois's third benchmark plan differs from its second benchmark plan in five ways, three of which specifically relate to opioid use disorder and one of which relates to mental health in general.³⁹ If you look at the screenshot of Illinois's third benchmark plan on this slide, you can see that it: (1) covers at least one intranasal opioid reversal agent prescription for certain initial prescriptions of opioids, a change from the second benchmark plan, which covered zero opioid reversal agents; (2) removes barriers to the prescription of medication-assisted treatment for opioid use disorder by removing prior authorization requirements, dispensing limits, first-fail policies, and lifetime limit requirements that used to be applicable to medication-

35. First Benchmark Plan Regulations, *supra* note 33; see Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812 (Feb. 27, 2015) (to be codified 45 C.F.R. pt. 144, 147, 153-56, and 158) [hereinafter Second Benchmark Plan Regulations]; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018) (to be codified at 45 C.F.R. pt. 147, 153-58) [hereinafter Third Benchmark Plan Regulations].

36. Third Benchmark Plan Regulations, *supra* note 35.

37. Tovino, *supra* note 3.

38. Centers for Medicare and Medicaid Services, *Information on Essential Health Benefit (EHB) Benchmark Plans*, Illinois Access to Care and Treatment Plan, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020-BPM-IL.zip> (last visited Nov. 30, 2018) [hereinafter Illinois Third Benchmark Plan]; Tovino, *supra* note 3, at Part III(A).

39. Illinois Third Benchmark Plan, *supra* note 38; Tovino, *supra* note 3, at Part III(A); Tovino PowerPoint, *supra* note 8, at Slide 20.

assisted treatment of opioid use disorder; and (3) limits opioid prescriptions for acute pain to no more than seven days, a controversial change on which Dr. Kelly Dineen is an expert.⁴⁰ In addition to these three specific, opioid-related changes, a fourth change benefits all individuals with mental health and substance use disorder services by covering tele-psychiatry.⁴¹

My survey found that prior authorization and prior certification are the most common substance use disorder coverage limitations or hurdles that an individual with substance use disorder must clear among all other states' second benchmark plans, which continue in effect through 2020, as well as Illinois's third benchmark plan.⁴² That is, at least twenty-eight out of fifty-one state benchmark plans require an insured to request and obtain prior authorization or to get the medical necessity of at least one substance use disorder service pre-certified.⁴³ Without such prior authorization or pre-certification, substance use disorder coverage may be denied, limited, or delayed.⁴⁴ These twenty-eight states include Nevada, which is my current state of residence; Nebraska, which is where we are today; as well as a number of states that are geographically close to Nebraska, including Colorado, Oklahoma, North Dakota, and Wisconsin.⁴⁵ Whether these prior authorization requirements are problematic from an inequity or injustice perspective depends on whether they are enforced and whether there are equivalent prior authorization requirements set forth on the physical health side or on the non-addiction mental health side. The federal Department of Health and Human Services requires state benchmark plans to comply with mental health parity laws,⁴⁶ but many of them do not, which leads to confusion when patients complain about a non-coverage decision that is in accordance with the terms of the health insurance policy but is inconsistent with mental health parity law.

40. See Illinois Third Benchmark Plan, *supra* note 38; Tovino PowerPoint, *supra* note 8, at Slide 20. See generally Kelly K. Dineen, *Definitions Matter: Defining Inappropriate Prescribing to Shape Effective Opioid Policy and Reduce Patient Harm*, KAN. L. REV. (forthcoming 2019) (critiquing regulation of physician opioid prescribing).

41. Illinois Third Benchmark Plan, *supra* note 38; Tovino, *supra* note 3, at Part III(A); Tovino PowerPoint, *supra* note 8, at Slide 20.

42. Tovino, *supra* note 3, at Part III(D).

43. *Id.*

44. *Id.*

45. *Id.*

46. 45 C.F.R § 156.115(a)(3) (2018). "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 . . . comply with the requirements of § 146.136 of this subchapter . . ." *Id.* See also *id.* § 146.136 (establishing mental health parity requirements).

One benchmark plan that is noteworthy in terms of its prior authorization requirement is that of Connecticut. It is noteworthy because its prior authorization requirement applies only to “outpatient treatment of opioid dependence” as you can see on this slide, but not to outpatient treatment of any other substance use disorder, such as cocaine use disorder.⁴⁷ Why the Connecticut Plan singles out opioid use disorder, but not other substance use disorders, for prior authorization is unclear. Are individuals with opioid use disorder any less deserving of immediate coverage than individuals with other substance use disorders? I think not.

My survey also revealed that, as written, twenty out of fifty-one state benchmark plans cover no opioid reversal agents.⁴⁸ The states that are geographically closest to Nebraska that fall into this category include Iowa, Minnesota, Oklahoma, and Utah.⁴⁹ Although ACA regulations currently require these benchmark plans to be read as including at least one opioid reversal agent,⁵⁰ the district court opinion striking down the entire ACA would reverse this regulatory fix,⁵¹ which means that if the district court opinion is affirmed and there is no applicable, state mandated benefit law that requires coverage of opioid reversal agents, we have twenty states with popular plans that, per their terms, do not cover an opioid reversal agent. This slide shows Iowa’s current benchmark plan, and you can see the zero, signaling that no opioid reversal agents are covered, in the lower, right-hand corner.⁵² My survey also shows that ten state benchmark plans, including the Nebraska benchmark plan, expressly exclude substance use disorder services that are provided in a residential treatment facility, which is where many individuals with substance use disorder are recommended to receive their care.⁵³

My survey also explores state benchmark plan coverage and exclusion provisions relating to methadone. Three states, Washington, Maryland, and Minnesota, specifically and expressly cover methadone as a treatment for substance use disorders.⁵⁴ On the other hand, six

47. Tovino PowerPoint, *supra* note 8, at Slide 22; ConnectiCare Insurance Company, Inc.: ConnectiCare Flex POS Plan at 82, available at <https://www.cms.gov/cciiio/resources/data-resources/ehb.html#Connecticut> (last visited March 9, 2019).

48. See Tovino, *supra* note 3, at Part III(E).

49. *Id.*

50. 45 C.F.R. § 156.122(a)(1)(i), (ii) (2018) (“A health plan does not provide essential health benefits unless it . . . covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan . . .”).

51. See *Texas*, 340 F. Supp.3d at 613-15 (discussing the inseparability of the individual mandate with the rest of the ACA’s provisions).

52. Tovino PowerPoint, *supra* note 8, at Slide 23.

53. *Id.* at Slide 24; Tovino, *supra* note 3, at Part III(F).

54. Tovino, *supra* note 3, at Part III(G).

states, Alabama, Arkansas, Delaware, Kentucky, Rhode Island, and Wisconsin, expressly exclude methadone from coverage.⁵⁵

Two states—Alabama and Mississippi—establish quantitative treatment limitations applicable only to substance use disorder benefits that I did not also see on the physical health benefit side or even on the non-addiction mental health side.⁵⁶ Mississippi, for example, covers only seven inpatient days and twenty outpatient days per year for individuals with substance abuse, but of course there are no parallel limitations for folks with physical health conditions.⁵⁷ Alaska is interesting in that it excludes from coverage all chemical dependency services, including opioid use disorder services, as you can see right here.⁵⁸ This exclusion provision runs counter to the ACA's EHB provision, which specifically requires coverage of mental health and "substance use disorder benefits."⁵⁹

My last example comes from Texas, where I attended law school and graduate school and where I am licensed to practice law. I like to pick on my own state. In Texas, we impose relatively low lifetime and annual spending caps—\$10,000 and \$5,000 respectively—on individuals who seek mental health care but we do not impose the same caps on individuals who seek physical health care.⁶⁰ These Texas provisions violate one ACA provision that extends MHPA to individual and small health plans⁶¹ as well as a second ACA provision that eliminates lifetime and annual spending caps applicable to EHBs, including mental health and substance use disorder services.⁶² And I will end by saying that this is how I got into health law in the first place, which is that my state has a rich history of mental health access and mental health insurance inequities and injustices. There is so much work to be done here. Thank you very much."

55. *Id.*

56. *Id.* at Part III(I).

57. *Id.*; Blue Cross Blue Shield of Mississippi: Network Blue at 13, available at <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Mississippi> (last visited Mar. 9, 2019).

58. Tovino, *supra* note 3, at Part III(J); Premera Blue Cross Blue Shield of Alaska: Alaska Heritage Select Envoy at 28, available at <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Alaska> (last visited Mar. 9, 2019).

59. See ACA, *supra* note 26, 1302(b)(1)(E).

60. Blue Cross Blue Shield of Texas: Blue Choice PPO RSH3 at 48, available at <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Texas> (last visited Mar. 9, 2019); Tovino PowerPoint, *supra* note 8, at Slide 29.

61. Tovino PowerPoint, *supra* note 8, at Slides 13-14; ACA, *supra* note 26, §§ 1311(j), 1563(c)(4).

62. ACA, *supra* note 26, at 1001.