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Can Mental Health Parity Be an Effective Tool to Challenge Inadequate Networks and Low Reimbursement Rates for Mental Health Clinicians?

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ABSTRACT

The United States is experiencing an unprecedented mental health crisis, worsened by the COVID-19 pandemic and systemic failures in the health insurance system. Despite the promise of the Mental Health Parity and Addiction Equity Act (MHPAEA), patients continue to face inadequate provider networks and discriminatory reimbursement rates for mental health services that severely limit access to care. This commentary examines the structural causes of network inadequacy—particularly the chronic underpayment of mental health clinicians by health insurers and third-party administrators—and explores the potential for MHPAEA to serve as a legal tool to challenge these barriers. Drawing on data from Milliman, RTI International, and government reports, the article highlights how low reimbursement rates drive clinicians out-of-network, forcing patients to bear higher out-of-pocket costs or forego care altogether. It analyzes the evolution of MHPAEA regulations, focusing on the 2024 rulemaking that explicitly linked reimbursement and network adequacy to parity requirements, and discusses the setback caused by the 2025 withdrawal of those regulations and funding cuts to the Department of Labor’s enforcement arm. Finally, the article considers state-level options and calls for continued advocacy, legislative reform, and legal action to ensure adequate mental health networks, fair reimbursement, and meaningful enforcement mechanisms. Without sustained pressure from clinicians, patients, and policymakers, true mental health parity will remain elusive.

KEYWORDS

Mental health parity; MHPAEA; network adequacy; access to care; provider reimbursement

The United States is currently facing a mental health crisis with soaring demand for mental health care, exacerbated by the impacts of social media and the ramifications of the COVID-19 pandemic. Yet, we are not well prepared to confront this crisis, as we also are suffering from a broken health insurance system, controlled by the for-profit health insurance industry that prioritizes its shareholders, not the patients it insures. Ensuring access to mental health care is critical if we are to address the problem, but that can only happen if we have enough clinicians available to serve those and if the patients in need can afford the care. This requires proper health insurance coverage and adequate networks so that patients are not priced out of the market by being forced to pay out-of-pocket because there are not enough clinicians who accept in-network rates. The problem is not the clinicians; the problem is the insurance industry that continues to discriminate against mental health care by underpaying clinicians and not prioritizing having sufficient networks to provide access to essential mental health care services.

The Mental Health Parity and Addiction Equity Act (“MHPAEA” or the “Federal Parity Act”) is intended to prohibit discrimination against patients suffering from mental health and substance abuse issues (referred to collectively herein as “mental health”). Whether it can be an

effective method to address inadequate mental health networks and low reimbursement rates remains an open question, however, and requires careful analysis and aggressive action. While the new MHPAE regulations that were issued in 2024 included significant efforts to address network adequacy concerns, and highlighted under-reimbursement of mental health clinicians as a parity issue, those regulations have now been withdrawn and cuts in regulatory funding will only make it more difficult to ensure proper enforcement. The road ahead will not be easy, but all involved in this fight to guarantee sufficient access to mental health care need to stay committed, now more than ever.

The failure of our health care system to address mental health issues

Unlike most developed countries, the U.S. does not have universal health care; 60% of U.S. citizens under 65 (165 million) have employer-sponsored health insurance, most governed by the Employee Retirement Income Security Act (“ERISA”).¹ This by itself creates complications, since most people are not free to seek the jobs that most fit their interests or lifestyle, but must find employment that offers the benefits they need, including, in particular, health care. But even when they do have coverage, all too often patients are left without access to mental health services, because of inadequate networks.

The impact of inadequate mental health networks on individuals and families who need mental health services, and cannot find the necessary resources, can be devastating. Relative costs are higher for mental health services because there are far fewer in-network options due to patently inadequate networks. This problem is exacerbated with Marketplace plans under the Affordable Care Act (“ACA”), where out-of-network services are often not even covered. While the ACA helped individuals obtain health insurance when not available through employment, this remains an inadequate solution, as the options in the ACA are too limited. According to the Paragon Health Institute, 50% of individual Marketplace consumers in 2014 were in benefit plans that allowed them to choose their providers, whether in- or out-of-network but this had dropped to 17% by 2023, with 83% of enrollees in restrictive health management organizations (“HMOs”) or exclusive provider organization (“EPOs”) that restrict coverage to network providers, except in the case of emergencies.² So given the inadequate mental health networks, the Marketplace plans fail to ensure access to the necessary mental health services.

A key part of the problem is that the insurers attempt to hide what is happening through “ghost networks,” in which a directory of providers is promulgated that have purportedly identified those who have agreed to treat its insureds on an in-network basis when, in reality, they have not. This is particularly pronounced in mental health networks. *ProPublica* recently published a major story on ghost networks, describing the effort for justice being sought by a mother whose son died after being unable to access a mental health provider because no one was available through the network.³ Reports on network adequacy for mental health have

¹See Claxton, *et al.*, “Employer-Sponsored Health Insurance 101,” KFF (May 28, 2024), <https://www.kff.org/health-policy/101-employer-sponsored-health-insurance/?entry=table-of-contents-what-is-employer-sponsored-health-insurance>; <https://www.associationhealthplans.com/group-health/what-is-erisa-health-insurance/> (80% of those with employer-based insurance (136 million) are governed by ERISA).

²See Paragon Health Institute, “ACA Individual Market Share by Network Type,” https://paragoninstitute.org/paragon-pic/aca-individual-market-share-by-network-type/?utm_source=chatgpt.com.

³See Max Blau, “‘I Don’t Want to Die’: Needing Mental Health Care, He Got Trapped in His Insurer’s Ghost Network,” *ProPublica*, Sept. 8, 2024, <https://www.propublica.org/article/ambetter-ghost-network-consequences>, See also “Reporter Max Blau Explains Insurance Ghost Networks,” Association of Health Care Journalists (Oct. 30, 2024), <https://healthjournalism.org/blog/2024/10/reporter-max-blau-explains-insurance-ghost-networks/>; Katherine Ellison, *73 doctors and none available: How ghost networks hamper mental health care*, *Wash. Post* (Feb. 19, 2022), <https://www.washingtonpost.com/health/2022/02/19/mental-health-ghost-network/>; Austin Frakt, *TheUpshot: Even Researchers Don’t Know Which Doctors Medicare Advantage covers*, *N.Y. Times* (July 8, 2019), <https://www.nytimes.com/2019/07/08/upshot/medicare-advantage-doctors-directories.html>.

similarly been issued by the Office of the New York Attorney General (“NYAG”),⁴ Congress⁵ and advocacy organizations.⁶

A May 2023 report by the United States Senate Finance Committee entitled “*Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks*” explains the problem in detail.⁷ The Committee’s majority staff reviewed 12 different provider directories across six states, finding that **over 80%** of the listed in-network providers were in reality “either unreachable, not accepting new patients, or not in-network.”⁸ Similarly, a March 2022 report by the United States Government Accountability Office corroborated this experience, concluding that “consumers with coverage for mental health care experience challenges finding in-network providers,” and that “[i]naccurate or out-of-date information on which mental health providers are in a health plan’s network contributes to ongoing access issues for consumers and may lead consumers to obtain out-of-network care at higher costs to find a provider.”⁹

The link between inadequate networks and under-reimbursements

The fact that inadequate mental health networks is so widespread has real world consequences. The Mental Health Treatment and Research Institute LLC, a not-for-profit subsidiary of The Bowman Family Foundation, engaged Milliman, a global actuarial and consulting firm, to prepare an analysis of in-network usage and reimbursement rates for medical versus mental health services. In its December 2017 report, Milliman found that patients used out-of-network providers far more frequently for mental health than for medical/surgical care. Between 2013 and 2015, the proportion of behavioral health out-of-network inpatient services was 2.8 to 4.2 times higher than for medical/surgical services, 3.0 to 5.8 times higher for outpatient services, 4.8 to 5.1 times for office visits, and 3.6 to 3.7 times higher for specialist visits.¹⁰ And whenever patients use out-of-network providers, they pay more out of pocket than they would with those who are in-network, thereby limiting access to care or leading people to forego care altogether as they cannot afford it, which is the unfair choice faced by lower income patients.

In addition, Milliman found significant differences in reimbursement rates when comparing mental health to medical/surgical services. Using the Medicare fee schedule as a basis for analysis, so as to create an apple-to-apple comparison, Milliman determined that, in 2015, primary care and medical/surgical specialists paid on average of 15.2% and 11.3% higher than the Medicare allowable, while behavioral health paid on average 4.9% **less** than Medicare allowable. At the same time, medical/surgical primary care services paid 21.2% higher than behavioral health, while medical/surgical specialists paid 17.1% higher, in comparison to Medicare. As for “evaluation and

⁴See “Inaccurate and Inadequate: Health plans’ mental health provider network directoris,” NYAG, Dec., 7, 2023, https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf.

⁵See, e.g., Press Release, Brown, Colleagues, Seek Information on Ghost Networks, Sherrod Brown U.S. Senator for Ohio (Jan. 30, 2023), <https://www.brown.senate.gov/newsroom/press/release/sherrod-brown-colleagues-seek-information-on-ghost-networks>; Laura Lovett, *Senators Call Out Aetna, Anthem BCBS, Humana, United Healthcare for Mental Health “Ghost Networks,”* Behavioral Health Bus. (Jan. 31, 2023), <https://bhbusiness.com/2023/01/31/senators-call-out-aetna-anthem-bcbs-humana-united-healthcare-for-mental-health-ghost-networks/>.

⁶See, e.g., <https://www.lac.org/assets/files/LAC-Network-Adequacy-Recommendations-for-NYS93.pdf> (“Meaningful access to quality, affordable substance use disorder and mental health care and treatment continues to be out of reach for many New Yorkers One key problem is that insurance networks often do not include a sufficient number of providers to serve their members’ needs.”).

⁷See *Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks*, U.S. Senate Fin. Comm. (May 3, 2023), <https://www.finance.senate.gov/hearings/barriers-to-mental-health-care-improving-provider-directory-accuracy-to-reduce-the-prevalence-of-ghost-networks>.

⁸*Id.* at 1.

⁹*Mental Health Care Access Challenges for Covered Consumers and Relevant Federal Efforts*, U.S. Gov’t Accountability Office, Report to the Chairman, Committee on Finance, U.S. Senate (Mar. 2022), <https://www.gao.gov/assets/gao-22-104597.pdf>, at 12.

¹⁰S. Melek, D. Perlman, S. Davenport, “Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates” (Milliman, Dec. 2017), <https://mhari.org/wp-content/uploads/2019/10/Milliman-Research-Report-NQTL-Disparity-Analysis-2017.pdf>.

management” (“E&M”) office visits, medical/surgical primary care and specialists paid 20.6% and 14.1% higher, respectively, for lower complexity E&M visits than psychiatrists, and 20.0% and 17.8% higher for moderate complexity E&M visits.

In a follow up report issued in November 2019, Milliman updated its report and shows widening disparities in network use and provider reimbursements.¹¹ Both Milliman Research Reports provide compelling evidence of the substantial disparities in the provision of mental health care services in this country as compared to medical/surgical services. All of this evidence suggests a strong link between low reimbursement rates for mental health clinicians and the inadequate mental health networks. Thus, it is, at least in part, precisely because the insurers refuse to pay mental health clinicians sufficiently that such a great percentage of them remain out-of-network, exacerbating the problem of lack of access to mental health services.

All of this raises questions of whether mental health parity remains out of reach. This was the focus of a 2024 study by RTI International, a nonprofit research institute, which further evaluated the data relating to the disparity between mental and physical health when examining out-of-network usage. Its primary findings confirm the Milliman reports by showing that patients went out-of-network 3.5 times more often for all mental health clinician office visits than for medical/surgical clinician visits (13.4% compared to 3.8%), while they did so 8.9 times more often for psychiatrist office visits than for medical/surgical specialist physicians (15.3% as compared to 1.7%) and 10.6 times more often for psychologist office visits (18.2% vs 1.7%). This was also true for inpatient facilities as well, with patients going to out-of-network inpatient acute mental health facilities 6.2 times more often than they did to medical/surgical acute facilities (9.0% compared to 1.5%), and they went to such facilities 19.9 times more often for mental health subacute facilities as compared to medical/surgical inpatient subacute facilities (34.5% vs. 1.7%).¹² In summarizing these results, the RTI Report stated:

High out-of-network use is a consequence of health plans contracting with too few providers. Many studies completed as recently as 2023 (...) demonstrate that behavioral health provider networks include too few providers. Studies also confirm that smaller provider networks (relative to the need for services) result in higher out-of-network use, higher patient out-of-pocket costs, and reduced access.

Turning to reimbursement levels, the RTI Report, as had the Milliman studies, similarly showed a significant connection, finding that “ongoing disparities in reimbursement can explain the material differences in out-of-network use.” The evidence of such disparities is clear:

- The average reimbursement for all medical/surgical office visits was 21.7% higher than for mental health (124.8% of Medicare for medical/surgical clinicians as compared to 102.5% of Medicare for mental health clinicians)
- The average reimbursement for medical/surgical specialist physician office visits was 24.9% higher than psychiatrist office visits (135.3% of Medicare compared to 108.4%), and 28.8% higher compared to psychologist office visits (135.3% vs. 105.1%).
- Even physician assistant office visits were paid far higher, relative to Medicare, than psychiatrists or psychologists (18.7% and 22.4% higher, respectively), while nurse practitioners were paid 8.2% and 11.5% more, relative to Medicare, than psychiatrists and psychologists.

Significantly, the facts looked even worse when RTI dug a little deeper. Recognizing that health plans have to increase reimbursements to attract top practitioners to ensure an adequate network, RTI looked at the clinicians that were paid at the highest levels. For example, for those clinicians who

¹¹See S. Davenport, T Gray, S. Melek, “Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement” (Milliman, Nov. 19, 2019), <https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-provider-reimbursement/>.

¹²T. Mark and W. Parish, “Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue” (RTI, April 17, 2024), <https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf>.

were at the 75th percentile of the reimbursement distribution (i.e., they were paid more than 75% of comparable providers overall), medical/surgical clinician office visits were paid 48.0% higher than mental health office visits (148.0% of Medicare compared to 100.0%). And at the 95th percentile, medical/surgical clinicians were paid 70.4% higher (279.9% of Medicare compared to 164.2%). This strongly suggests that insurers will pay more, if necessary, to obtain sufficient clinicians for medical/surgical services, but are not disposed to do the same for mental health.

Some have argued that the main obstacle to access to mental health care, and the reason for more out-of-network use for mental health services, is because there are too few clinicians to meet the need. While more mental health clinicians are certainly needed, however, that is not the cure for this problem. RTI pointed out that there are even greater shortages for primary care physicians (“PCPs”) than for mental health clinicians, and, yet, there was a much lower out-of-network use for PCPs (2.2%) than for psychiatrists (15.3%) and psychologist (18.2%). And PCPs similarly are paid higher than psychiatrists relative to Medicare (155.9% of Medicare at the 75th percental for PCPs, compared to 127.4% for psychiatrists, and 297.4% vs. 208.8% at the 95th percentile). So, even though there is a greater shortage of PCPs than of mental health clinicians, and even though some PCPs have opened up out-of-network concierge practices, patients are not using out-of-network PCPs nearly as often as they are out-of-network mental health clinicians. Patients are therefore able to use their health insurance benefits, which they pay for with their monthly premiums, to access PCP care in-network, their most affordable and convenient option, but this is something often unavailable for mental health services.

This evidence highlights how low reimbursement rates contribute to poor mental health networks. As the RTI Report noted:

Health plans’ key levers for establishing the size of their provider networks are the in-network reimbursement rates that they offer to providers. Providers who are offered low reimbursement from health plans are less likely to participate in networks, resulting in smaller provider networks, more out-of-network use, and less access to treatment.

Thus, the only way to address the inadequate networks is if the health insurance companies, whether operating as insurers in fully insured plans or as third-party administrators for employers in self-funded plans, prioritize having a sufficient mental health network by paying enough to attract clinicians. But this will not happen on its own. After all, most of the insurers are for-profit companies that, like most publicly traded companies, owe their primary obligations to their shareholders. So if they can save money by reducing reimbursement to clinicians, they will. Effective enforcement of mental health parity might be the solution, if the significant hurdles that remain can be overcome.

Mental health parity regulations with regard to inadequate networks

The first federal parity law, the Mental Health Parity Act of 1996 (“MHPA”), took initial, albeit limited, steps toward protecting mental health benefits by requiring that lifetime and annual dollar limits on mental health benefits for large employer group plans that provided mental health coverage be no more restrictive than those for medical/surgical benefits. Due to the narrow focus of the statute, including that it did not address substance use disorder benefits or non-quantitative treatment limits (“NQTL”), such as prior authorization or non-numeric restrictions on coverage, it was expanded significantly in 2008 through MHPAEA.

Codified into ERISA through 29 U.S.C. § 1185a, MHPAEA added substance use disorder treatments and expanded the coverage of the parity law to go beyond the lifetime and annual limits that were part of MHPA so as to also include other “financial requirements,” including “deductibles, coinsurance, and out-of-pocket expenses,” as well as non-quantifiable “treatment limitations,” including “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.” With regard to these categories, the law required that

they be “no more restrictive than the predominant” financial requirements or treatment limitations than were “applied to substantially all medical and surgical benefits covered by the plan (or coverage),” and that there be “no separate” cost sharing requirements or treatment limitations “that are applicable only with respect to mental health or substances use disorder benefits.”¹³

While these provisions are important, it is notable that inadequate networks and discriminatory payments are not specified in the statute. And from the statutory language itself, employers and health insurances might well argue that the statute simply does not address the issues at all. For example, the argument would have to be that if a patient is forced to go out-of-network because there were not sufficient in-network clinicians available that would result in higher out-of-pocket costs so as to fall within the “financial requirements” provision. This is a bit of a convoluted argument that a court might well reject. And even then, the statute requires showing that such financial requirements are more “restrictive” than those for medical/surgical services, raising a question as to how the term “restrictive” can reasonably be interpreted to apply to networks or reimbursement rates, let alone how a patient or clinician could gain access to enough data to prove this. The argument can be made that the statute nevertheless speaks to network inadequacy and under-reimbursement, but it’s not straightforward.

The first MHPAEA regulations issued by the three agencies jointly responsible for implementing and enforcing MHPAEA, namely the Department of Labor (“DOL”), the federal agency responsible for administering ERISA, the Department of the Treasury (“Treasury”) and the Department of Health and Human Service (“HHS”) (collectively, the “Agencies”), sought to clarify what type of practices would constitute an NQTL. While not discussed extensively, the initial regulations did refer generally to reimbursement rates. Noting that “some commenters have asked how the NQTL requirements apply to provider reimbursement rates,” the Agencies stated that “[p]lans and issuers may consider a wide array of factors in determining provider reimbursement rates for both medical/surgical services and mental health and substance use disorder services, such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers.” They then added that “[t]he NQTL provisions require that these or other factors be applied comparably to and no more stringently than those applied with respect to medical/surgical services,” but that “disparate results alone do not mean that the NQTLs in use fail to comply with these requirements.”¹⁴

The problem with these regulations is that they were too vague, giving insurers the right to consider numerous factors in setting reimbursements so that it would be next to impossible to prove a parity violation, even when, as has been proven to be true, mental health providers are being paid far less on a relative basis than medical/surgical providers, contributing to severe discrepancies in network adequacy. This is highlighted with the following discussion in the regulations:

In particular, the regulations do not require plans and issuers to use the same NQTLs for both mental health and substance use disorder benefits and medical/surgical benefits, but rather that the processes, strategies, evidentiary standards, and other factors used by the plan or issuer to determine whether and to what extent a benefit is subject to an NQTL are comparable to and applied no more stringently for mental health or substance use disorder benefits than for medical/surgical benefits.¹⁵

As a result, as long as insurers could argue that they used the same “processes” and “strategies” to set reimbursement rates, that would satisfy parity, even if the result was patently inadequate mental health networks and reimbursement rates.

In a subsequent MHPAEA “self-compliance tool” promulgated by the DOL in 2020, it sought to confirm how disparities in reimbursement rates could be considered when evaluating parity, stating:

¹³29 U.S.C. § 1185a(a)(3).

¹⁴“Final Rules” under MHPAEA, 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013), <https://www.govinfo.gov/content/pkg/FR-2013-13/pdf/2013-27086.pfd>.

¹⁵*Id.* at 68,245.

With respect to provider reimbursement, comparing a plan or issuer's average reimbursement rates for both medical/surgical and MH/SUD providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's or issuer's reimbursement rates warrants additional review for compliance with MHPAEA. Furthermore, evaluating how medical/surgical and MH/SUD providers are reimbursed for the same or similar services may also help a plan or issuer determine if the plan's or issuer's underlying methodology for provider reimbursement warrants further review.¹⁶

While at least pushing further than the original rules, the DOL still did not say that inadequate networks or poor reimbursement by themselves would violate parity, but only that variations might indicate a need for "further review" to evaluate the "underlying methodology for provider reimbursement." So if the "methodology" for setting rates was consistent, there would be no parity violation, even if there was a clear cut disparity in reimbursement rates in the final results.

The regulations also failed to address network adequacy. Indeed, the term "network adequacy" was only used once in the commentary to the regulations, stating:

Specifically, plan standards, such as in- and out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, *and network adequacy, while not specifically enumerated in the illustrative list of NQTLs, must be applied in a manner that complies with these final regulations.*¹⁷

This provides at least some ability to argue that inadequate networks could create a parity violation, but given its absence from the statute and the lack of any details in the regulations, such a claim would be difficult to win.

In 2024, the Biden Administration issued voluminous new and far more detailed regulations for MHPAEA. In an apparent recognition of the failure to address network adequacy and provider reimbursement sufficiently in the original regulations, those topics were far more prominent in the new version. As stated in a Fact Sheet promulgated by the DOL to highlight the new regulations, they were designed, among other things, to:

Codify the requirement in MHPAEA, as amended by the Consolidated Appropriations Act, 2021, that health plans and issuers conduct comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates, and medical management and prior authorization NQTLs.¹⁸

The Fact Sheet further confirmed that NQTLs under MHPAEA included "standards related to network composition, and methodologies to determine out-of-network reimbursement rates."¹⁹

The Final Rules themselves, as codified at 29 CFR § 2590.712, confirm this summary by explicitly identifying network adequacy and reimbursement rates as NQTLs:

Standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, *and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage.*

Plan or issuer methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates.²⁰

¹⁶See "Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA), <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

¹⁷78 Fed. Reg. 68240, at 68,246 (emphasis added).

¹⁸Final Rules under the Mental Health Parity and Addiction Equity Act (MHPAEA) Fact Sheet, <https://www.dol.gov/sites/dolgov/files/ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea.pdf>, at 1.

¹⁹*Id.*

²⁰29 CFR § 2590.712(b)(4)(ii) (emphasis added).

To address these NQTLs, the new regulations also required “outcomes data” to be gathered by plans or issuers “[t]o ensure” that NQTLs were not in use which were in violation of MHPAEA, with such data being “reasonably designed to assess the impact of the [NQTL] on relevant outcomes relating to access” to mental health care. Examples of “relevant data ... related to network composition” included “in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates (for comparable services and as benchmarked to a reference standard).”²¹ Moreover, the regulations specified that “[t]o the extent the relevant data” gathered “suggest that the [NQTL] contributes to material differences in access to mental health and substance use disorder benefits, the plan or issuer **must take reasonable action**, as necessary to address the material differences to ensure compliance,” while documenting “the actions that have been or are being taken by the plan or issuer to address material differences in access” to mental health care.²²

The regulations further identified, in a section entitled “Nonquantifiable treatment limitations related to network adequacy,” what “reasonable actions” the plan or issuer might be required to take when the data suggested violations “related to network composition,” which included:

- (1) Strengthening efforts to recruit and encourage a broad range of available mental health and substance use disorder providers and facilities to join the plan’s or issuer’s network of providers, including taking actions to increase compensation or other inducements, streamline credentialing processes, or contact providers reimbursed for items and services provided on an out-of-network basis to offer participation in the network;
- (2) Expanding the availability of telehealth arrangements to mitigate any overall mental health and substance use disorder provider shortages in a geographic area;
- (3) Providing additional outreach and assistance to participants and beneficiaries enrolled in the plan or coverage to assist them in finding available in-network mental health and substance use disorder providers and facilities; and
- (4) Ensuring that provider directories are accurate and reliable.²³

The regulations were a giant step forward to addressing the clear problem of inadequate mental health networks and recognizing that the key causal factor for such a result was discriminatory underpayments to mental health clinicians. It is nevertheless unclear from the regulations, which were only issued a year ago, how effective the enforcement may be. In addition, while the new regulations were issued pursuant to 42 USC § 300gg-19, which is incorporated into ERISA through 29 U.S.C. § 1185d, it is not clear cut that private litigants could sue to enforce these provisions relating to network adequacy and provider reimbursement, as opposed to courts limiting remedies to regulatory enforcement actions. As an ERISA litigator, I would argue that plaintiffs should be able to enforce these provisions if it could be shown that a patient was forced to go out-of-network for mental health services due to underpayments and inadequate networks, but this is a cutting edge argument that is seeking to create new precedents. In any event, however, the new regulations were a clear advancement toward the goal of actual MHPAEA enforcement, including by establishing important standards under the Act, highlighting the connection between reimbursement and network adequacy, and laying out the type of action that could be taken to address inadequate networks (including through increased compensation for mental health clinicians).

One Step Forward; Two Steps Back

Unfortunately, before any steps could be taken to enforce the new regulations, they were withdrawn. On January 17, 2025, shortly before the Trump Administration took over, the

²¹*Id.* at (4)(iii)(A)(2).

²²*Id.* at (4)(iii)(A)(2) (emphasis added).

²³*Id.* at (4)(iii)(C).

ERISA Industry Committee (“ERIC”) sued to enjoin the regulations, claiming that the new regulations had exceeded the Agencies’ statutory authority.²⁴ With the new Administration coming in shortly thereafter, it had a choice. It could have appeared in the case to defend the new regulations (which would have been the best result for addressing our mental health crisis); it could have stated that it would not be defending the regulations (and thereby potentially allowing another party to intervene in the action to defend the case on behalf of the U.S.); or it could have asked the court for stay (i.e., to put the case on hold) in order to allow the new Administration to reconsider the regulations, thereby effectively mooting the litigation. The Administration took the last option, effectively handing a victory to ERIC and a defeat to MHPAEA enforcement.

On May 9, 2025, the Trump Administration filed a motion in the ERIC lawsuit to “hold this case in abeyance pending the Departments’ reconsideration of the rule challenged in this litigation,”²⁵ which was granted by the Court on May 12, 2025.²⁶ Shortly thereafter, the Trump Agencies announced that they “will not enforce the 2024 Final Rule or otherwise pursue enforcement actions, based on a failure to comply that occurs prior to a final decision in the litigation, plus an additional 18 months.”²⁷ At the same time, the Agencies would “undertake a broader reexamination of each department’s respective enforcement approach under MHPAEA,” with plans and issuers instructed to continue to refer to the original 2013 regulations.²⁸ In other words, the Trump Administration elected to put the new MHPAEA regulations on the back burner, including its important focus on network adequacy and underpaid mental health benefits. This constituted a major victory for the profit-motivated health insurance industry and a devastating blow to the mental health community.

So where does that leave us? Effectively, things are back to 2013. The new regulations that focused on network adequacy and reimbursement for mental health providers are no longer in effect. There is no way of knowing whether or when the Federal Government will decide if any part of the regulations should remain in force. Thus, we are left with the 2013 regulations that do not provide sufficient support for aggressive action to apply MHPAEA as a tool to challenge inadequate networks and seek increased reimbursement for mental health care.

Despite these setbacks, the DOL can continue to work to enforce MHPAEA, working through the Employee Benefits Security Administration (“EBSA”), the DOL arm responsible for enforcing ERISA and the Federal Parity Act. Yet, even here, difficulties are appearing. On September 2, 2025, the House Committee on Appropriations proposed a \$10 million budget cut for EBSA, down to \$118.1 million, for fiscal year 2026, along with a total cut to the DOL of 28%, reducing its budget by \$4 billion, down to \$9.6 billion.²⁹ This proposal was made by President Trump in June, in which he had EBSA request \$10 million less in 2026, or the equivalent of cutting 47 full-time employees. The former EBSA head under President Biden, Lisa Gomez, explained the potential impact of these cuts:

²⁴The ERISA Industry Committee, “ERIC Sues to Stop Recent Biden Administration Mental Health Regulations, Saying New Regulations Overstep Existing Mental Health Parity Law” (Jan. 17, 2025 Press Release), eric. https://www.eric.org/press_release/eric-sues-to-stop-recent-biden-administration-mental-health-regulations-saying-new-regulations-overstep-existing-mental-health-parity-law/.

²⁵Defendants’ Motion for Abeyance, *The ERISA Industry Committee v. U.S. Department of Health and Human Services*, Civ. Act. No. 25–0136(TJK) (D.C.D.C. May 9, 2025), <https://www.eric.org/wp-content/uploads/2025/05/2025.05.09-Dkt.-14-Motion-for-Abeyance.pdf>.

²⁶ECF Notice, *The ERISA Industry Committee v. U.S. Department of Health and Human Services*, Civ. Act. No. 25–0136(TJK) (D.C.D.C. May 12, 2025), <https://www.eric.org/wp-content/uploads/2025/05/MHP.pdf>.

²⁷“Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury regarding enforcement of the final rule on requirements related to the Mental Health Parity and Addiction Equity Act” (May 15, 2025), <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/statement-regarding-enforcement-of-the-final-rule-on-requirements-related-to-mhpaea>.

²⁸*Id.*

²⁹Plan Sponsor Council of America, “House Republicans Pitch \$10 M Cut to EBSA” (Sept. 2, 2025), [https://www.pasca.org/news/pasca-news/2025/9/house-republicans-pitch-\\$10m-cut-to-ebsa/](https://www.pasca.org/news/pasca-news/2025/9/house-republicans-pitch-$10m-cut-to-ebsa/).

I quite frankly do not see how it will be possible for EBSA to in any way effectively deliver upon its mission of safeguarding the retirement, health, and other benefits of more than 156 million American workers and their families, much less provide the critical guidance and assistance needed by the employers, professionals, labor organizations, service providers and medical providers who offer or work closely with the millions of plans that EBSA deal with. In the time I was at EBSA, up until my very last day, I was sounding the alarm bells that EBSA needed additional funding and additional staff to be able to deliver on all its responsibilities to the public and that an existential crisis was looming.³⁰

So here we are. While confronting a mental health crisis, and dealing with patently inadequate mental health networks and a pattern of discriminatory payments to mental health clinicians by our for-profit health insurance industry, the detailed regulations adopted to address the problem have been deferred, if not scrapped altogether, while the funding for our primary regulator is being cut. Things are not looking good.

Can States overcome federal inaction?

In light of the failure of the federal system to provide a means for addressing network adequacy and underpayments, state law may need to be assessed as an alternative option. However, that, too, has significant limitations.

As an initial matter, self-funded ERISA plans, which most large employers use, preempt *all* state laws, so that even very vigorous state mental health parity acts do not apply to them. And approximately 60% of individuals covered by ERISA are in self-funded plans where state laws do not apply.³¹ The number is even higher for the largest insurance companies, with almost 80% of the commercial business of UnitedHealthcare, for example, being self-funded.³² This means that, for most people, *only* federal law applies.

Despite this fact, there still are many people in fully insured ERISA plans or those exempt from ERISA, where state insurance laws are not preempted, including with respect to Marketplace plans. However, there is another – and perhaps more significant – limitation, in that many such state laws do *not* have a provision permitting consumers to sue to enforce statutory requirements. For example, the New York State parity act, known as Timothy’s Law, seems strong on its face, but individuals cannot sue to enforce it because it does not have a private right of action. Instead, enforcement can only come through the state regulators. While the regulators potentially could help with enforcement, substantive regulatory actions are rare and in the absence of any risk of private litigation, the ability to enforce the law is severely restricted. As I wrote in an opinion piece I published in the *Times Union* over seven years ago:

When it comes to protecting citizens’ core needs — from housing to employment to banking — we rarely leave it exclusively to government regulators. For health laws to have meaning, individuals must be empowered to seek justice when corporations act illegally. Forcing patients to complain to an under-funded and disinterested government agency is not nearly enough, and it removes any hope of pressuring insurers to obey the law and honor the promises made in the terms of our health plans.³³

I thus called for amending Timothy’s Law “to provide an indisputable private right of action [to] restore the law’s original intent and give it teeth.” That has not happened.

³⁰Plan Sponsor Council of America, “Trump Proposal Slims EBSA Budget” (June 3, 2025), <https://www.pasca.org/news/pasca-news/2025/5/trump-proposal-slims-ebbsa-budget/>.

³¹B. Telkamp, “What Is ERISA Health Insurance?,” Association Health Plans, Inc. (June 30, 2020), <https://www.associationhealthplans.com/group-health/what-is-erisa-health-insurance/> (“According to the DOL’s 2018 Report to Congress, there were approximately 2.2 million ERISA-covered health plans in 2015 covering approximately 136 million people. It is estimated that approximately 60% of these individuals were covered by a self-funded ERISA health plan and the remaining 40% were covered under a fully insured ERISA health plan. Today, ERISA health insurance is the single largest segment of the U.S. health insurance market.”).

³²See *Peterson v. UnitedHealth Group Inc.*, 2017 WL 9,910,043, *1 (D. Minn.) (“United’s fully insured business accounts for 22% of all claim payments; the remainder come from self-insured plans.”).

³³See B. Hufford, “Commentary: Diluting Timothy’s Law: Insurers, regulators weaken mental health,” *Times Union* (May 12, 2018), <https://www.timesunion.com/opinion/article/Commentary-Diluting-Timothy-s-law-12909739.php>.

What to do Now

It is easy to become frustrated under the current circumstances, and even to give up the fight, but that cannot be the solution. Continued advocacy and activism are necessary to bring these issues to the forefront and push for change. Seeking new legislation at both the federal and state level to address inadequate mental health networks, and underpaid mental health clinicians, is essential. While the country is widely divided politically, the importance of addressing our mental health crisis remains a topic that appears of interest on both sides of the aisle. We need to take advantage of that. Mental health clinicians should be signing petitions and writing letters concerning where we are, and must reach out to their representatives at the federal, state and local levels about the need to address the situation. Meeting with insurance companies and employers to explain the importance of mental health care and how it will save money in the long run could create incremental change. Working with provider and patient organizations can enhance the effectiveness of these efforts, as difficult as they may be. Lobbying to create formal requirements to ensure adequate mental health networks, and to eliminate discriminatory reimbursement for mental health clinicians, while also providing a private right of action to allow citizens to enforce the law, is necessary. And lawyers must continue to push the envelope in fighting back against health insurance abuses.

Times are not easy. But this is too important to look away. Keep up the fight.

Notes on contributor

D. Brian Hufford, Esq. recently opened up his own law firm, The Hufford Law Firm PLLC, where he focuses on advocacy and public policy in the health insurance space, and, among other things, works with law students offering pro bono assistance to individuals appealing health insurance denials. He is the founder and former leader of health insurance practices at two prior firms, where he represented patients and clinicians in disputes over health insurance coverage and reimbursement. Mr. Hufford current serves on the Board of Directors and on the Executive Committee of the Psychotherapy Action Network (“PsiAN”). He is one of the leading national experts in this field.

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