UNLV | William S. Boyd SCHOOL OF LAW

Scholarly Commons @ UNLV Law

Scholarly Works | Faculty Scholarship

2011

Reforming State Mental Health Parity Law

Stacey A. Tovino
University of Nevada, Las Vegas -- William S. Boyd School of Law

Follow this and additional works at: http://scholars.law.unlv.edu/facpub

Part of the Health Law Commons, Insurance Law Commons, and the Psychology and Psychiatry Commons

Recommended Citation
Tovino, Stacey A., "Reforming State Mental Health Parity Law" (2011). *Scholarly Works.* Paper 686.
http://scholars.law.unlv.edu/facpub/686

This Article is brought to you by Scholarly Commons @ UNLV Law, an institutional repository administered by the Wiener-Rogers Law Library at the William S. Boyd School of Law. For more information, please contact david.mcclure@unlv.edu.

11 HOUS. J. HEALTH L. & POL'Y 455–504
Copyright © 2011 Stacey A. Tovino
Houston Journal of Health Law & Policy
ISSN 1534-7907

REFORMING STATE MENTAL HEALTH PARITY LAW

Stacey A. Tovino, J.D., Ph.D.*

INTRODUCTION

This Article is the final installment in a three-part project that presents a comprehensive challenge to lingering legal distinctions between physical and mental illness in the context of health insurance. The first installment in this series narrowly inquired as to whether the postpartum mood disorders should be classified as physical or mental illnesses in a range of health law contexts.[1] The second installment was broader in scope and challenged a number of federal provisions that allow publicly- and privately-funded health care programs and plans to provide mental health insurance benefits that are less comprehensive than their physical counterparts.[2] The second installment also proposed comprehensive federal reforms, including the extension of federal mental health parity law to

* Professor of Law, William S. Boyd School of Law, University of Nevada, Las Vegas. I thank John Valery White, Dean, William S. Boyd School of Law, for funding this research project. I also thank Jeanne Price (Director, Wiener-Rogers Law Library), Chad Schatzle (Student Services Librarian, Wiener-Rogers Law Library), and Cheryl Grames (Boyd law student) for their outstanding assistance in locating many of the sources referenced in this Article. I am grateful to the participants of the following conferences and meetings for their helpful comments and suggestions on earlier drafts of this Article: The 26th Annual Whittier Health Law Symposium sponsored by Whittier Law School, The 33rd Annual Health Law Professors Conference sponsored by the American Society for Law, Medicine & Ethics, and The 63rd Annual Meeting of the Southeastern Association for Law Schools.

1 *See* Stacey A. Tovino, *Scientific Understandings of Postpartum Illness: Improving Health Law and Policy?* 33 HARV. J.L. & GENDER 99 (2010).

2 *See* Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Parity Law*, 49 HARV. J. ON LEGIS. (forthcoming 2012).

individuals who do not currently benefit from mental health parity law.[3] This third and final piece undertakes an important correction of state mental health parity law.

As I explained in the introduction to my second installment, my aim with this project is to examine the boundaries of the concept of health and to question the idea that individuals with mental illness are less deserving of legal protection and benefits than individuals with physical illnesses.[4] My purpose in this particular piece is to examine the patchwork of state law addressing mental health parity and to question the logic, scientific bases, and empirical accuracy of the assumptions underlying state law.

The first section of this Article examines in detail the mental health parity laws of four states: Idaho, Maryland, Nevada, and Vermont.[5] I categorize these states' divergent mental health parity laws by their breadth and depth of application, whether they mandate the option or inclusion of mental health and substance use disorder benefits, and the extent to which parity between physical and mental health benefits is required in all rates, terms, and conditions.[6] The second section of this Article justifies and proposes amendments that would not only conform these and other state laws to minimum federal requirements,[7] but would also expand state mental health parity law to all health plans subject to state insurance regulation;[8] require inclusion of mental health and substance use disorder benefits in such plans;[9] and eliminate artificial "biologically-based" and "severe mental illness" distinctions.[10] The third section of this Article offers a uniform mental health parity law for consideration by state legislatures.[11]

---

3 *Id.*

4 *Id.*

5 *See infra* Section I.

6 *See infra* Section I.

7 *See infra* Section II(A).

8 *See infra* Section II(B).

9 *See infra* Section II(B).

10 *See infra* Section II(B).

11 *See infra* Section III.

I. A PATCHWORK OF STATE MENTAL HEALTH PARITY LAW

Mental health parity refers to the financing of mental health care on the same basis as the financing of physical health care.[12] Most states have mental health parity laws that are designed to minimize or eliminate mental health insurance benefit disparities, although these laws vary widely in their application and scope.[13] As discussed below, some state mental health parity provisions apply only to "group health plans," defined as employee welfare benefit plans that provide medical care to "employees or their dependents directly or through insurance, reimbursement, or otherwise."[14] Some state mental health parity laws are further limited in that they only apply to the group health plans of large employers, usually defined as those that employ at least fifty-one employees,[15] while other state mental health parity laws are broader in scope and also apply to the group health plans of small employers, usually defined as those that employ no more than fifty employees.[16] In addition to group health plans,

---

12 *See, e.g.*, U.S. DEP'T OF HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 405, 426 (1999) [hereinafter SURGEON GENERAL REPORT] (describing the concept of mental health parity and explaining that, "The fundamental motivation behind parity legislation is the desire to cover mental illness on the same basis as somatic illness, that is, to cover mental illness fairly.").

13 *See, e.g.*, NAT'L CONFERENCE OF STATE LEGISLATURES, STATE LAWS MANDATING OR REGULATING MENTAL HEALTH BENEFITS (2010) [hereinafter NCSL] *available at* http://www.ncsl.org/default.aspx?tabid=14352 (explaining that mental health insurance benefits have been the object of a variety of state legislation and reporting that forty-nine states and the District of Columbia have some type of law regulating mental health benefits); *see also* NAT'L ALLIANCE ON MENTAL ILLNESS, STATE MENTAL HEALTH PARITY LAWS (2009) (surveying, comparing and contrasting state mental health parity laws).

14 42 U.S.C. § 300gg–91(a)(1) (2010) (defining group health plan); 29 U.S.C. § 1002(1) (2010) (defining employee welfare benefit plan).

15 *See, e.g.*, 42 U.S.C. § 300gg–91(e)(2) (2010) (defining large employer under federal law as "an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year."); MD. CODE ANN., INS. § 15-802(a)(5) (West 2010) (defining large employer under Maryland's mental health parity law as "an employer that has more than 50 employees and is not a small employer.").

16 *See, e.g.*, 42 U.S.C. § 300gg–91(e)(4) (2010) (defining small employer under federal law as "an employer 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

some state mental health parity laws also apply to individual health plans, defined as plans that provide or pay the cost of medical care for individuals and that are offered to individuals in the individual market, that is, other than in connection with a group health plan.[17] Finally, some state mental health parity laws apply to publicly-offered, publicly-administered, and/or publicly-funded health care plans in addition to purely private health care plans.[18]

States also vary with respect to the mental illnesses that are protected by their parity laws. Some state mental health parity laws are designed to protect individuals with almost any psychiatric, neurological, substance abuse, developmental, or intellectual disorder from insurance discrimination.[19] Other state laws are limited to a handful of very traditional psychiatric illnesses that have significant and longstanding support in the clinical literature and that are typically referred to as "biologically-based disorders" or "severe mental illnesses" (such as major depression, bipolar disorder, and schizophrenia, but not substance use disorders, autism, or post-traumatic stress disorder).[20]

Finally, states also vary with respect to the financial and administrative rates, terms, and conditions that may be imposed on mental health insurance benefits. Some states require parity between

---

the first day of the plan year."); MD. CODE ANN., INS. § 15-1203(b)(1)(i) (West 2010) (defining small employer under Maryland insurance law as an employer that employs "at least two but not more than 50 eligible employees, the majority of whom are employed in the State . . . .").

17 *See* 42 U.S.C. § 300gg–91(b)(1), (5), and (e)(1) (2010) (defining health insurance coverage, individual health insurance coverage, and individual market).

18 *See, e.g.*, VT. STAT. ANN. tit. 8, § 4089b(b)(1) (West 2011) (Vermont mental health parity provision that applies to all health insurance plans issued in the state, including any health insurance policy or health benefit plan offered by a health insurer as well as any health benefit plan offered or administered by the State of Vermont or any subdivision thereof).

19 *See, e.g.*, *infra* text accompanying notes 44–45 (describing Vermont's mental health parity law, which protects individuals with any diagnosis listed in the mental disorders section of the current edition of the International Classification of Disease, which includes a broad range of psychiatric, neurological, substance use, developmental, and intellectual disorders).

20 *See, e.g.*, NEV. REV. STAT. § 689A.0455(8)(a)–(f) (West 2010) (protecting only those individuals who have one of six "severe mental illnesses" that are "biologically based," including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder).

physical and mental health benefits in all rates, terms, and conditions, including deductibles, copayments, coinsurance, inpatient day limitations, partial hospitalization hour or day limitations, and outpatient visit limitations.[21] Other states require parity between physical and mental health benefits in less than all of these rates, terms, and conditions.[22]

The regulation of insurance, including health insurance, traditionally has been a state responsibility,[23] and Sections I(A)

---

21 *See, e.g.*, VT. STAT. ANN. tit. 8, § 4089b(c)(1) (West 2011)("A health insurance plan [in Vermont] . . . shall: not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental health condition than for access to treatment for other health conditions . . . .").

22 *See, e.g.*, *infra* text accompanying notes 62–64 (explaining that Maryland law does not require parity in the partial hospitalization and outpatient benefit contexts).

23 *See* 15 U.S.C. § 1012(a) (2010) ("The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business."). Congress also, however, reserved to itself the right to pass federal legislation that specifically relates to the business of insurance. 15 U.S.C. § 1012(b) (2010) (stating, "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . . ."). In addition, the Employee Retirement Income Security Act of 1974 (ERISA) preempts state laws that relate to an employee benefit plan (29 U.S.C. § 1144(a)) if such state laws are not saved from preemption by ERISA's 'savings clause,' which saves from preemption state laws that regulate insurance (29 U.S.C. § 1144(b)(2)(A)). Moreover, ERISA's 'deeming clause' provides that employee benefit plans are neither insurance companies, insurers, nor in the business of insurance for purposes of state insurance law. 29 U.S.C. § 1144(b)(2)(B). One result of these provisions is that self-insured employee health benefit plans are regulated by ERISA, not state insurance law. *See generally* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 733–746 (1985) (holding that a Massachusetts law requiring insured employee health benefit plans to provide certain mandated mental health benefits is saved from ERISA preemption under the savings clause); *id*. at 747 (explaining, "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing, we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter."); Kevin Caster, *The Future of Self-Funded Health Plans*, 79 IOWA L. REV. 413, 413 (1994) ("ERISA . . . does preempt state laws relating to self-funded health insurance plans. . . . The federal government has jurisdiction over self-funded [health] plans . . . ."); Daniel W. Sherrick, *ERISA Preemption: An Introduction*, 64 MICHIGAN BAR J. 1074, 1074 (1985) (exploring selected topics relating to ERISA preemption); Robert S. McDonough, *ERISA Preemption of State Mandated Provider Laws*, 1985 DUKE L.J. 1194, 1194 (1985) (examining ERISA preemption issues raised by state mandated provider laws). The second installment in this three-part series proposes health insurance reforms that are appropriate for the federal

through (D), *infra*, demonstrate how widely states vary in their regulation of health insurance, including mental health insurance. All states have insurance codes that regulate the business of insurance and impose standards on insurance carriers, including rating rules, consumer protections, licensing requirements, and solvency standards, among others.[24] Most states also require insurance policies sold in the state to include (or provide a purchase option for) certain health insurance benefits, such as emergency services, mammogram services, and phenylketonuria services.[25] Some states have many health insurance benefit mandates,[26] while other states have few benefit mandates.[27] Insured health plans are subject to state insurance

government. Tovino, *supra* note 2. This installment proposes health insurance reforms that are appropriate for state insurance regulators.

24 *See, e.g.*, Nevada Insurance Code, codified at NEV. REV. STAT. §§ 679A.010–697.370 (West 2010); Texas Insurance Code, codified at TEX. INS. CODE ANN. §§ 30.001–7002.003 (West 2010).

25 *See, e.g.*, COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES (2008) (summarizing state health insurance mandates and noting that almost all states identify emergency services, mammogram services, and phenylketonuria services as mandated benefits).

26 The State of Washington, for example, requires certain individual and group health plans to: (1) cover fourteen different health care services, including anesthesia for dental services, chemical dependency services, colorectal cancer exams and diagnostic tests, congenital anomalies in children and newborns, diabetes coverage, emergency medical services provided in an emergency department, injuries caused by intoxication or narcotics, mammograms, maternity and drug coverage, mental health services, neurodevelopmental therapies, phenylketonuria, prostate cancer screening, and women's health care services; (2) offer the option for insureds to purchase coverage for three additional sets of health care services, including home health care and hospice, prenatal diagnosis of congenital disorders, and temporomandibular joint disorder; and (3) allow insureds access to ten different types of health care providers, including chiropractors, dentists, denturists, optometrists, podiatrists, chiropodists, psychologists, registered nurses, advanced registered nurse practitioners, and women's health care practitioners. *See generally* WASH. STATE OFFICE OF INS. COMM., SUMMARY OF STATE AND FEDERAL MANDATED HEALTH BENEFITS (2008) (summarizing Washington and federal mandated health benefits); WASH. REV. CODE ANN. §§ 48.44.309–48.44.500 (West 2010) (establishing Washington's mandated health benefits).

27 Idaho has the lowest number (seventeen) of health insurance benefit mandates. *See* Michael Bihari, *Mandated Benefits: Understanding Mandated Health Insurance Benefits*, ABOUT.COM (Feb. 11, 2010), http://www.healthinsurance.about.com/od/reform/a/mandated_benefits_overview.htm. ("The states differ greatly in the number and type of mandated benefits. The state of Idaho has the lowest number of mandates at 17 . . . .").

regulation, including state-mandated health insurance benefits, while self-insured health plans usually are exempt from state health insurance mandates.[28]

In the sections below, I examine in detail the mental health parity laws of Idaho, Maryland, Nevada, and Vermont. The laws of Vermont and Maryland, which require almost all categories of health plans to implement comprehensive mental health parity, are examined first. The laws of Nevada and Idaho, which continue to allow inferior mental health insurance benefits in many contexts, are analyzed second. I selected the laws of these four states to illustrate, but not exhaust, the varying scope of state mental health parity regulation.

A. Vermont: Broad Application, Mandated Benefit, and Full Parity

On May 28, 1997, Vermont Governor Howard Dean signed into law House Bill 57, "An Act Relating to Health Insurance for Mental

---

[28] In an insured individual (or group) health plan, an individual (or plan sponsor) purchases (group) health insurance from a state-licensed insurance carrier for the individual (or on behalf of the members of the group). In a self-insured group health plan, the plan sponsor funds the health benefits directly, thus bearing the financial risk of group members' medical expenses. Because insured plans are purchased from an insurance carrier licensed by the state, insured plans are subject to state insurance regulation, including state-mandated health insurance benefits. Employee Retirement Income Security Act (ERISA)-preempted self-insured plans, on the other hand, are exempt from state requirements and subject only to federal regulation. A majority of individuals with private health insurance coverage are enrolled in self-insured group health plans. *See generally supra* note 23; CONG. RESEARCH SERV., SELF-INSURED HEALTH INSURANCE COVERAGE (May 12, 2010) (providing background information about self-insured health insurance coverage and explaining the differences between insured and self-insured health plans); NAT'L ACAD. FOR STATE HEALTH POLICY, ERISA PREEMPTION PRIMER (2008), *available at* http://nashp.org/sites/default/files/ERISA_Primer.pdf?q=Files/ERISA_Primer.pdf. (providing an overview of ERISA preemption principles relevant to state health policy initiatives); Robert W. Miller, *The Effect of the Health Reform Act on Self-Insured Employer Health Plans*, 4 J. HEALTH & LIFE SCI. L. 59, 77 (2010) ("One of the benefits of an ERISA-preempted, self-insured employer health plan has been that the employer can provide uniform health benefits across state lines without having to comply with the benefits mandated under state health insurance laws . . . ."); NCSL, *supra* note 13, ("'[S]elf-funded' health insurance plans, often sponsored by the largest employers, usually are entirely exempt from state regulation because they are preempted by the federal ERISA law.").

Health and Substance Abuse Disorders" (the "Vermont law").[29] The goals of the Vermont law include recognizing treatment for mental health conditions as an integral component of health care and ensuring that health plans cover all necessary and appropriate health care services, including necessary physical and mental health care services.[30] To this end, the Vermont law broadly regulates all health insurance plans, including any health insurance policy or health benefit plan offered by a health insurer as well as any health benefit plan offered or administered by the State of Vermont or any subdivision thereof.[31] Health insurers are defined to include health insurance companies, nonprofit hospital and medical service corporations, and managed care organizations, as well as the administrators of insured, self-insured, and publicly funded health care benefit plans offered by public and private entities.[32]

As discussed in more detail in Section II(A) of this Article, neither the federal Mental Health Parity Act of 1996[33] nor the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008[34] requires private insurers to offer or include insurance benefits for mental illness in their health plans.[35] At present and unless otherwise prohibited by a state mental health parity law such as Vermont's, private health insurers are thus permitted to sell individual policies and group health plans that

---

29 An Act Relating to Health Insurance for Mental Health and Substance Abuse Disorders, Vt. H. 57, 1997–1998 Leg. Sess. H. 57, 1997–1998 Leg. Sess. (Vt. 1997).

30 VT. STAT. ANN. tit. 8, § 4089b(a) (West 2011) (stating, "It is the goal of the general assembly that treatment for mental health conditions be recognized as an integral component of health care, that health insurance plans cover all necessary and appropriate medical services . . . and that integration of health care be recognized as the standard for care . . . .").

31 *See* VT. STAT. ANN. tit. 8, § 4089b(b)(1) (West 2011).

32 *See* VT. STAT. ANN. tit. 18, § 9402(7) (West 2011) (defining 'health insurer').

33 Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 701 et seq., 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a (2006)) [hereinafter MHPA].

34 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, in the Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, Subtitle B, § 511 et seq., 122 Stat. 3756, 3881 (2008) [hereinafter MHPAEA].

35 29 U.S.C. § 1185a(b)(1) (2010) (stating, ''Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits").

contain benefits for illnesses traditionally classified as physical, such as cancer and pregnancy, but that do not contain benefits for illnesses traditionally classified as mental, including major depression and bipolar disorder. Under the Patient Protection and Affordable Care Act of 2010, mental health and substance use disorder benefits must be part of the essential benefit package offered by certain health plans beginning in 2014;[36] however, as discussed in more detail in Section II(A), this provision does not go into effect until the year 2014 and, when in effect, the provision will not apply to all health plans.[37]

The Vermont law, unlike the 1996 and 2008 federal mental health parity laws, requires all health insurance plans to include coverage for mental health conditions: "A health insurance plan shall provide coverage for treatment of a mental health condition . . . ."[38] The Vermont law thus may be categorized as a mandated benefit law. Mandated benefit laws require all health insurance plans to include the mandated benefit (here, mental health insurance benefits)

---

[36] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 111th Cong., 2nd Sess. (2010) [hereinafter, PPACA], *as amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 111th Cong., 2nd Sess. (2010) [hereinafter, HCERA] [collectively and hereinafter, the Affordable Care Act (ACA)] § 1302(b)(1)(E) (stating, "essential health benefits . . . shall include . . . [m]ental health and substance use disorder services, including behavioral health treatment."); *id*. § 1201 (adding new 42 U.S.C. § 300gg-6(a) (codified at Section 2707(a) of the Public Health Service Act and stating, "A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act")).

[37] As discussed in more detail in Section II(A) of this Article, grandfathered health plans are exempt from the essential health benefits requirement. A 'grandfathered plan' may be defined as a health plan that was in effect on March 23, 2010, the day President Obama signed PPACA into law. *See* 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. 34538, 34562 (June 17, 2010) (adding new 29 C.F.R. § 2590.715–1251(a), which defines 'grandfathered health plan coverage' as "coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010.); *id*. at 34559 (explaining that Section 2707 of the Public Health Service Act does not apply to grandfathered health plans); *id*. at 34563 (adding new 29 C.F.R. 2590.715–1251(c)(1) (stating, "[T]he provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans.")). *See also* DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., APPLICATION OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS ACT TO GRANDFATHERED PLANS 1 (June 17, 2010) (explaining that ACA's essential benefit package requirement is not applicable to grandfathered plans).

[38] VT. STAT. ANN. tit. 8, § 4089b(c) (West 2011).

regardless of whether a particular insured requires or believes she will require the benefit.[39] Mandated offer laws, on the other hand, only require health insurance plans to provide an offer, or an option, of coverage for a particular condition (here, mental illness) that the prospective insured is free to accept or reject.[40] If the insured accepts the offered benefit, the plan usually will require the insured to pay an additional or higher premium.[41] Mandated benefit laws are believed to protect insurers from the problem of adverse selection which, in the mental health insurance context, refers to the concern that plans that provide mental health benefits will attract individuals with greater mental health care needs, leading to higher service usage and costs for such insurers.[42] Historically, many insurers have not offered mental health benefits as a way of controlling for adverse selection,[43] although laws such as Vermont's minimize concerns relating to adverse selection because all health plans are required to provide mental health benefits.

The Vermont law broadly defines the phrase "mental health condition" to include all mental illnesses listed in the mental disorders section of the current edition of the International Classification of Disease (ICD).[44] Chapter V of the 10th revision of the ICD classifies dozens of mental disorders within eleven broad categories, including: (i) organic mental disorders, such as Alzheimer's disease; (ii) substance use disorders, including alcohol abuse; (iii) schizophrenia, schizotypal and delusional disorders, including paranoid schizophrenia; (iv) mood disorders, including bipolar disorder; (v) neurotic, stress-related, and somatoform

---

39 *See, e.g.*, NCSL, *supra* note 13 (defining and distinguishing "mandated benefit" and "mandated offer" laws).

40 *See, e.g.*, *id.*

41 *See, e.g.*, *id.*

42 *See, e.g.*, SURGEON GENERAL REPORT, *supra* note 12, at 420.

43 *Id.*

44 VT. STAT. ANN. tit. 8, § 4089b(b)(2) (West 2011) (stating, "'Mental health condition' means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised."). *See also* WORLD HEALTH ORG., INTERNATIONAL CLASSIFICATION OF DISEASE, 10th rev. (2007) [hereinafter ICD-10] (including a broad range of mental and behavioral disorders in Chapter V).

disorders, including obsessive-compulsive disorder; (vi) behavioral syndromes associated with physiological disturbances and physical factors, including eating disorders; (vii) adult behavioral and personality disorders, including pathological gambling; (viii) mental retardation, including mild, moderate, and severe retardation; (ix) disorders of psychological development, including autism; (x) behavioral and emotional disorders with onset usually occurring in childhood and adolescence, including attention deficit disorder; and (xi) other mental disorders not otherwise specified.[45] The Vermont law thus requires health insurance plans to cover the full range of neurological, psychiatric, substance abuse, developmental, and intellectual disorders.

In addition to its mandated benefit requirement, the Vermont law also prohibits health insurance plans from discriminating against individuals with mental illness by charging separate and higher co-payments, coinsurance amounts, or deductibles for mental health care.[46] Vermont insureds may be asked to pay only one combined deductible or out-of-pocket limit for both physical and mental health care.[47] The Vermont law also prohibits health insurance plans from excluding from their network or list of authorized providers any licensed mental health or substance use abuse provider located within the geographic coverage area of the health benefit plan if the provider is willing to meet the terms and conditions for participation established by the health insurer.[48] Referred to as "any willing provider" laws, provisions such as these prohibit health insurers from refusing to allow psychiatrists, psychologists, social workers, licensed professional counselors, and other mental health care

---

45 *See* ICD-10, *supra* note 44, at Chapter V (containing eleven mental and behavioral disorder classifications ranging from F00–F99).

46 *See* VT. STAT. ANN. tit. 8, § 4089b(c)(1) (West 2011) (stating, "A health insurance plan . . . shall: not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental health condition than for access to treatment for other health conditions . . . .").

47 *See id.* § 4089(c)(3) (stating, "A health insurance plan . . . shall: make any deductible or out-of-pocket limits required under a health insurance plan comprehensive for coverage of both mental health and physical health conditions.").

48 VT. STAT. ANN. tit. 8, § 4089b(c)(2) (West 2011).

providers into their networks.[49] Any willing provider laws ensure that members with mental health conditions have access to health care providers with mental health expertise (and that health insurers cannot make an end-run around parity requirements by agreeing in theory to parity but in practice having no in-network or authorized mental health care providers that members with mental illness can access).

The Vermont law applies to all health insurance plans offered or renewed in the state on or after January 1, 1998.[50] A health insurer that violates the Vermont law may be subject to a civil monetary penalty, a cease and desist order, a remediation order, and suspension or revocation of its insurance license.[51] The Vermont Department of Health Care Administration (HCA) requires the state's largest insurers to file annual reports containing information regarding the mental health and substance abuse treatments they cover, the amount of money spent on mental health and substance abuse treatments, and mental health and substance abuse treatment denials.[52] The HCA, together with the Vermont Mental Health and Substance Abuse Task Force, issues an annual "Health Insurer Mental Health and Substance Abuse Report Card" that is made available to the public.[53]

B. Maryland: Broad Application, Mandated Benefit, and Some Parity

On February 28, 1994, Maryland Governor William Donald Schaefer signed into law Senate Bill 756, "An Act Concerning Health Insurance—Mental Illness, Emotional Disorders, Drug Abuse, and

---

49 *See, e.g.*, NCSL, *supra* note 13 (referring to the Vermont provision as an 'any willing provider' provision).

50 H. 57, 1997–1998 Leg. Sess. (Vt. 1997).

51 *See* VT. STAT. ANN. tit. 8, § 4089(d)(4)(A)–(D) (West 2011).

52 *See* VT. DEP'T OF BANKING, INS., SEC., & HEALTH CARE ADMIN., VERMONT'S HEALTH INSURANCE COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT (2010).

53 *Id*. The most recent Health Insurer Mental Health and Substance Abuse Report Card, dated January 15, 2011, is available at http://www.bishca.state.vt.us/sites/default/files/Act129LegRpt1-11-11_0.pdf.

Alcohol Abuse" (the "Maryland law").[54] As currently codified, the Maryland law applies to each health insurance policy or contract that is delivered or issued for delivery in the state to an employer or individual on a group or individual basis and that provides coverage on an expense-incurred basis.[55] The heart of the Maryland law is a provision that prohibits a health insurance policy or contract from discriminating against an individual with a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder by failing to provide benefits for the diagnosis and treatment of such illnesses and disorders under the same terms and conditions that apply for the diagnosis and treatment of physical illnesses.[56] Because it requires health insurance policies and contracts to provide mental health benefits, the Maryland law also may be classified as a mandated benefit law. Unlike Vermont, which expressly protects individuals with any mental disorder listed in the ICD, Maryland does not refer to the ICD; however, Maryland's broad reference to "mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder" suggests that individuals with almost any type of mental illness or substance use disorder will be protected.[57] The Maryland law does not clarify whether it protects individuals with disorders or disabilities that may be classified as intellectual or developmental, such as autism, attention-deficit disorder, and mental retardation.

The extent of mental health benefit parity in Maryland depends on whether the mental health service is delivered on an inpatient,[58] partial hospitalization,[59] or outpatient[60] basis. With respect to

---

54 S.B. 756, 1994 Md. Laws Ch. 2 (Reg. Sess.).

55 *See* MD. CODE ANN., INS. § 15-802(b) (West 2010).

56 *Id*. § 15-802(c).

57 *Id*.

58 An inpatient may be defined as a patient who: "(i) receives room, board and professional services in a medical institution for a 24-hour period or longer; or (ii) is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours." 42 C.F.R. § 440.2(a) (2010).

59 Partial hospitalization may be defined as "the provision of medically directed intensive or intermediate short-term treatment: (i) to an insured, subscriber, or member; (ii) in a licensed or certified facility or program; (iii) for mental illness, emotional disorders, drug abuse, or

inpatient benefits, Maryland requires the total number of days for which mental health benefits are payable and the terms and conditions that apply to such mental health benefits to be at least equal to those that apply to physical illness benefits.[61] Stated slightly differently, Maryland requires full mental health benefit parity in the context of inpatient services.

Maryland does not require full parity for partial hospitalization and outpatient benefits, however. Instead, Maryland permits health insurance policies and contracts to cover only sixty days of partial hospitalization for mental illnesses even if such policies and contracts cover more than sixty days of partial hospitalization for individuals with physical illnesses.[62] In addition, Maryland permits individual health plans and group contracts covering employees of small employers[63] to impose increasing coinsurance amounts on insureds for outpatient services provided to treat mental illness and substance use disorders, including a twenty percent coinsurance for the first five visits in a calendar year or benefit period of not more than twelve months, a thirty-five percent coinsurance for the sixth through thirtieth visit in the same year or period, and a fifty percent coinsurance for the thirty-first visit and any subsequent visits in the same year or period.[64] Individual health plans and group contracts covering employees of small employers may impose these increasing coinsurance amounts on outpatient services for mental illness and substance abuse even if the coinsurance for outpatient services

---

alcohol abuse; and (iv) for a period of less than 24 hours but not more than 4 hours in a day." MD. CODE ANN., INS. § 15-802(a)(7) (West 2010).

60 An outpatient may be defined as "a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight." 42 C.F.R. § 440.2(a) (2010).

61 MD. CODE ANN., INS. § 15-802(d)(1) (West 2010).

62 *See id.* §§ 15-802(d)(2), (d)(3)(i).

63 *Id.* § 15-1203(b)(1) (defining small employer as an employer that employs "at least two but not more than 50 eligible employees, the majority of whom are employed in the State . . . ."). *Id.* 15-1203(b)(1)(i).

64 *See id.* § 15-802(d)(4)(i)–(iii) (allowing the imposition of the increasing coinsurance amounts). *But see id.* § 15-802(d)(5) (prohibiting group contracts covering employees of one or more large employers from imposing the increasing coinsurance amounts).

provided to treat physical illnesses remains constant or otherwise is set at a lower percentage.

Group contracts covering employees of large employers[65] must establish parity in the context of coinsurance amounts.[66] Except for the increasing coinsurance amounts that individual health plans and group contracts covering employees of small employers are permitted to impose on mental health and substance abuse services, no health insurance policy or contract in Maryland may impose separate or otherwise lower lifetime maximums for treatment of mental illness, separate or otherwise higher deductible or coinsurance amounts for treatment of mental illness, or separate or otherwise higher out-of-pocket limits for treatment of mental illness.[67]

C. Nevada: Uneven Mental Health Parity Standards

On June 9, 1999, Nevada Governor Kenny Guinn signed into law Senate Bill 557, which contained a mental health parity provision that applies to health insurance policies sold in the individual market in the State of Nevada.[68] As currently codified, this Nevada provision contains mandated benefit language: "a policy of health insurance delivered or issued for delivery in this state pursuant to this chapter must provide coverage for the treatment of conditions relating to severe mental illness."[69] The mandated benefit language only applies, however, to six mental illnesses that the State of Nevada has determined to be "severe mental illnesses," including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder.[70] The Nevada

---

65 MD. CODE ANN., INS. § 15-802(a)(5) (West 2010) (defining large employer under Maryland's mental health parity law as "an employer that has more than 50 employees and is not a small employer.").

66 *See id.* § 15-802(d)(5) (prohibiting group contracts covering employees of one or more large employers from imposing the increasing coinsurance amounts).

67 *See id.* § 15-802(e)(5)(i)–(iii).

68 S.B. 557, § 1, 1999 Leg., Reg. Sess. (Nev. 1999) codified at NEV. REV. STAT. ANN. § 689A.0455 (LexisNexis 2009).

69 NEV. REV. STAT. ANN. § 689A.0455(1) (LexisNexis 2009).

70 *Id.* § 689A.0455(8)(a)–(f).

provision thus may be referred to as a limited mandated benefit law.

The Nevada provision is limited in its parity requirements as well. Nevada only requires individual health insurance policies to cover forty inpatient days and forty outpatient visits per policy year for insureds with severe mental illnesses even if insureds with mild or severe physical illnesses have an unlimited number of inpatient days and outpatient visits.[71] The Nevada provision further emphasizes that in no event is an individual health insurance policy required to cover more than forty inpatient days per policy year for individuals with severe mental illness[72] or provide benefits for psychosocial rehabilitation or care received as a custodial inpatient.[73] In addition, deductibles and copayments required to be paid for mental health care may be up to 150% higher than the out-of-pocket expenses required to be paid for physical health care under the same policy.[74] An individual health insurance policy that is delivered, issued for delivery, or renewed on or after January 1, 2000, has the legal effect of including the coverage required by these Nevada statutory provisions, and any contractual provision of the health insurance policy or renewal thereof that conflicts with the Nevada statutory provisions is considered void.[75]

During the 1999 Legislative Session, the Nevada Legislature enacted a second, separate provision that requires the benefits provided by an individual health insurance policy for treatment of alcohol or drug abuse to include: (i) a minimum benefit of $1,500 per calendar year for treatment for withdrawal from the physiological effect of alcohol or drugs; (ii) a minimum benefit of $9,000 per calendar year for treatment provided to a patient admitted as an inpatient to an alcohol or drug abuse facility; and (iii) a minimum benefit of $2,500 per calendar year for counseling for a person, group or family who is not admitted to an alcohol or drug abuse facility.[76]

---

71 *See id.* § 689A.0455(2)(a)(1).

72 *Id.* § 689A.0455(2)(a)(2).

73 *Id.* § 689A.0455(2)(b).

74 NEV. REV. STAT. ANN. § 689A.0455(3) (LexisNexis 2009).

75 *Id.* § 689A.0455(7).

76 *Id.* § 689A.046(1)(a)–(c).

These alcohol and drug abuse treatment benefits "must be paid in the same manner as benefits for any other illnesses covered by a similar policy are paid"[77] so long as the treatment is provided through: (i) an alcohol or drug abuse treatment facility certified by the Health Division of the Nevada Department of Health and Human Services (NHHS); or (ii) a hospital or other medical facility that is licensed by NHHS, accredited by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission), and "provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities."[78]

The severe mental illness and alcohol and drug abuse benefit provisions discussed above only apply to individual health insurance policies sold in the individual (or non-group) market.[79] This changed on May 29, 2009, when Nevada Governor Jim Gibbons signed Senate Bill 426 into law.[80] Senate Bill 426 amends the statutory provisions that regulate small group health plans[81] to include a mental health parity provision.[82] Like its counterpart that regulates individual health insurance policies, the provision that applies to small group health plans also contains a mandated benefit law: "a policy of group health insurance delivered or issued for delivery in this State pursuant to this chapter must provide coverage for the treatment of conditions relating to severe mental illness."[83] Like its individual health insurance policy counterpart, the small group health plan provision only protects individuals who have one of six mental

---

77 *Id.* § 689A.046(2).

78 *Id.* § 689A.046(3)(a)–(b).

79 *See* NEV. REV. STAT. ANN. § 689A (LexisNexis 2009) (regulating "Individual Health Insurance").

80 Edwards, Angell, Palmer & Dodge, *Nevada Enacts New Viatical Settlements Law*, INSUREREINSURE.COM (June 18, 2009, 9:34 AM), http://www.insurereinsure.com/blog.aspx?entry=1722.

81 NEV. REV. STAT. ANN. § 689C.095 (LexisNexis 2009). Nevada defines a small group health plan as a health plan of a small employer, defined as "an employer who employed on business days during the preceding calendar year an average of at least 2 employees, but not more than 50 employees, who have a normal workweek of 30 hours or more, and who employs at least 2 employees on the first day of the plan year." *Id.*

82 S.B. 426, 75th Leg., Reg. Sess. (Nev. 2009).

83 NEV. REV. STAT. ANN. § 689C.169(1) (LexisNexis 2009).

illnesses identified as "severe mental illnesses," including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder.[84] Also like its individual health insurance policy counterpart, the small group health plan provision only requires small group health plans to cover forty inpatient days and forty outpatient visits per policy year for individuals with severe mental illnesses.[85] Small group health plans are not required to provide benefits for psychosocial rehabilitation or care received as a custodial inpatient,[86] and any deductibles and copayments required to be paid for mental health coverage may be up to 150% higher than the out-of-pocket expenses required to be paid for physical health benefits under the plan.[87] Small group health insurance policies delivered, issued for delivery, or renewed on or after October 3, 2009, have the legal effect of including the coverage described in this paragraph, and any provision of the policy or the renewal that conflicts with the requirements described in this paragraph is void.[88]

The Nevada legislature included a second, separate provision in the May 29, 2009, legislation that requires small group health plans to include a provision for benefits payable for expenses incurred for the treatment of abuse of alcohol or drugs.[89] The benefits provided for the treatment of alcohol or drug abuse must consist of: (i) "[t]reatment for withdrawal from the physiological effects of alcohol or drugs, with a minimum benefit of $1,500 per calendar year;" (ii) "[t]reatment for a patient admitted to a facility, with a minimum benefit of $9,000 per calendar year;" and (iii) "[c]ounseling for a person, group or family who is not admitted to a facility, with a minimum benefit of $2,500 per calendar year."[90] "These benefits must be paid in the same manner as benefits for other illness[es] covered

---

84 *Id.* § 689C.169(8)(a)–(f).

85 *Id.* § 689C.169(2)(a)(1).

86 *Id.* § 689C.169(2)(b).

87 *Id.* § 689C.169(3).

88 NEV. REV. STAT. ANN. § 689C.169(7) (LexisNexis 2009).

89 *Id.* § 689C.166.

90 *Id.* § 689C.167(1)(a)–(c).

by a similar policy are paid[,]"[91] so long as the treatment is provided through: (i) an alcohol or drug abuse treatment facility certified by NHHS; or (ii) a hospital or other medical facility that is licensed by NHHS, accredited by the Joint Commission, and "that provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities."[92]

The Nevada provisions described thus far apply to individual health insurance policies sold in the individual (or non-group) market as well as policies sold in the small group market. Prior to 2009, Nevada law also contained additional, separate mental health and substance use disorder parity provisions that applied to large group health plans,[93] nonprofit corporations for hospital, medical, and dental services,[94] and health maintenance organizations (HMOs).[95] In 2009, the Nevada Legislature repealed these provisions,[96] replacing them with one generic provision that requires an insurer or other organization providing health coverage through a group health plan, nonprofit corporation for hospital, medical, and dental services, or HMO, among other methods of insurance delivery, to comply with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations.[97] As discussed in Section II(A), *infra*, the MHPAEA does not require its covered group health plans to offer benefits for mental illness or substance abuse.[98]

---

91 *Id.* § 689C.167(2).

92 *Id.* § 689C.167(3)(a)–(b).

93 *See* NEV. REV. STAT. ANN. §§ 689B.0359, 689B.036 (2008), (repealed 2009).

94 *See id.* §§ 695B.1938, 689B.194 (2008), (repealed 2009).

95 *See id.* §§ 695C.1738, 689C.174 (2008), (repealed 2009).

96 S.B. 426, Ch. 365 § 104, 75th Leg., Reg. Sess. (Nev. 2009), *available at* http://leg.state.nv.us/Division/Legal/LawLibrary/States/75th2009/stats200918.html#Chz365_2SB2426.

97 *Id.* § 37 (stating, "[a]n insurer or other organization providing health coverage pursuant to chapters 689B, 695A, 695B, 695C or 695F of NRS shall comply with the provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 . . . and any federal regulations issued pursuant thereto.").

98 *See* 29 U.S.C. § 1185a(b)(1) (2010) (stating "[n]othing in this section shall be construed . . . as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health . . . benefits.").

If mental health and substance use disorder benefits are offered, however, they may not be more restrictive than offered physical health benefits in terms of financial requirements such as deductibles, copayments, and coinsurance,[99] as well as treatment limitations such as inpatient day and outpatient visit limitations.[100]

Also on May 29, 2009, Nevada Governor Jim Gibbons signed Assembly Bill 162, "An Act Relating to Insurance; Requiring Certain Policies of Health Insurance and Health Care Plans to Provide an Option of Coverage for Screening for and Treatment of Autism" (the "Nevada Autism Provision"), into law.[101] The Nevada Autism Provision amends the Nevada statutory provisions that regulate individual health plans,[102] group and blanket health plans,[103] small group health plans,[104] HMOs,[105] and managed care organizations[106] to require all such health plans to provide an option (but not a mandate) of coverage for screening for and diagnosis of autism spectrum disorders (including autism, Asperger's disorder, and pervasive developmental disorder) for minors as well as individuals enrolled in high school until they reach the age of twenty-two.[107] The optional coverage must feature a minimum benefit of $36,000 per

---

99 *See id.* § 1185a(a)(3)(B)(i) (defining 'financial requirement' to include deductibles, copayments, and coinsurance); *id.* § 1185a(a)(3)(A)(i) (stating, in the case of a covered group health plan, "the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan.").

100 *See id.* § 1185a(a)(3)(B)(iii) (defining 'treatment limitation' to include "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment"); *see also id.* § 1185a(a)(3)(A)(ii) (stating, in the case of a covered group health plan, "the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan.").

101 *See* A.B. 162, 75th Leg. (Nev. 2009).

102 *See* NEV. REV. STAT. ANN. § 689A.0435 (LexisNexis 2009).

103 *See id.* § 689B.0335.

104 *See id.* § 689C.1655.

105 *See id.* § 695C.1717.

106 *See id.* § 695G.1645.

107 *See, e.g.*, NEV. REV. STAT. ANN. § 689A.0435(1), (7)(b).

year for applied behavior analysis treatment.[108] Regulated health plans that provide coverage for outpatient care are not permitted to "[r]equire an insured to pay a higher deductible, copayment, or coinsurance" amount for treatment for an autism spectrum disorder, or require a longer waiting period for optional coverage for outpatient care related to an autism spectrum disorder, than that which is required for other outpatient care covered by the policy.[109] Regulated health plans also may not "[r]efuse to issue a policy of health insurance," and may not cancel a policy of health insurance solely because the individual applying for insurance uses or may use a treatment for an autism spectrum disorder.[110] Finally, regulated health plans generally may not "[l]imit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders."[111] The Nevada Autism Provision became effective January 1, 2011.[112]

As a result of Nevada's busy 2009 legislative session, rather uneven mental health parity standards apply in Nevada. Individual health insurance policies and small group health plans must provide health insurance benefits for individuals who have one of six severe mental illnesses; however, these benefits may be less comprehensive than the benefits provided to individuals with physical illnesses and may include only forty covered inpatient days, forty covered outpatient visits, and 150% higher deductibles, copayments, and other out-of-pocket expenses.[113] Individual health insurance policies and small group health plans also must provide health insurance benefits for individuals with alcohol and drug abuse disorders; however, these benefits only have a required minimum annual floor of $1,500, $9,000, and $2,500, depending on whether the benefit is for substance withdrawal, inpatient care, or outpatient counseling,

---

108 *See, e.g.*, *id*. § 689A.0435(2)(a).

109 *See, e.g.*, *id*. § 689A.0435(3)(a).

110 *See, e.g.*, *id*. § 689A.0435(3)(b).

111 *See, e.g.*, *id*. § 689A.0435(4).

112 *See, e.g.*, NEV. REV. STAT. ANN. § 689A.0435.

113 *See supra* text accompanying notes 72–74 and 85–87.

respectively.[114] Individual health insurance policies, group and blanket health plans, small group health plans, HMOs, and managed care organizations must offer insurance benefits for autism spectrum disorders with a minimum of $36,000 annual coverage for applied behavioral analysis as well as equal copayments, deductibles, and coinsurance amounts.[115] On the other hand, large group health plans and other health insurers in Nevada are not required to offer or provide any mental health or substance use disorder benefits other than the autism spectrum disorder benefits required to be offered by the Nevada Autism Provision.[116] If a large group health plan or other insurer does offer mental health and substance use disorder benefits, Nevada law (by reference to the MHPAEA) requires such benefits to not be more restrictive than their physical benefit counterparts in terms of deductibles, copayments, coinsurance, inpatient day limitations, outpatient visit limitations, and other financial requirements and treatment limitations.[117]

D. Idaho: Limited Parity for State Employees and Family Members

On March 21, 2006, Idaho Governor Dirk Kempthorne signed House Bill 615 into law, creating Idaho's first mental health parity law.[118] The Idaho law was designed to implement an Idaho anti-discrimination policy benefitting state employees and their spouses and children who have serious mental illnesses and emotional disturbances and to provide for the treatment of serious mental illnesses and emotional disturbances in an equitable manner commensurate with the treatment provided for other major physical illnesses.[119] To this end, the Idaho law requires state group health

---

114 *See supra* text accompanying notes 76 and 90.

115 *See* A.B. 162, 75th Leg. (Nev. 2009).

116 *See supra* text accompanying notes 93–98.

117 *See supra* text accompanying notes 93–100.

118 H.B. 615, 58th Leg., 2nd Reg. Sess. (Id. 2006).

119 IDAHO CODE ANN. § 67-5761A(1) (LexisNexis 2010) (stating, "[i]t is the policy of the state of Idaho that state employees and their spouses with serious mental illnesses and state employees whose children have been diagnosed with serious emotional disturbances must not be discriminated against in group health care service coverages" and, "[s]uch coverages

coverage to "provide benefits and cover services that are essential to the effective treatment of serious mental illnesses and serious emotional disturbances in a manner that: (a) [i]s not more restrictive or more generous than benefits and coverages provided for other major illnesses; (b) [p]rovides clinical care, but does not require partial care, of serious mental illness or serious emotional disturbance; and (c) [i]s consistent with effective and common methods of controlling health care costs for other major illnesses."[120]

The Idaho law is rather limited in application. As currently written, the Idaho law only benefits state employees, spouses of state employees, and children of state employees.[121] Non-state employees and their family members do not benefit from the parity law. In addition, the Idaho law only benefits state employees and their family members who are covered by a state-sponsored group health plan.[122] Thus, state employees who opt out of state-provided coverage, perhaps to obtain dependent coverage under a spouse's or partner's private health care plan, also do not benefit from the Idaho law. Similar to the Nevada provisions that apply to individual health insurance plans and small group health plans, the Idaho law only establishes parity for state employees and spouses who have one of seven "serious mental illnesses," defined to include schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizoaffective disorders, panic disorders, and obsessive-compulsive disorders.[123] Thus, the Idaho law does not

---

must provide for the treatment of serious mental illnesses and serious emotional disturbances in a manner that is equitable and commensurate with that provided for other major physical illnesses.").

120 *Id.* § 67-5761A(3)(a)–(c).

121 *See id.* § 67-5761A(1) (applying the Idaho law to "state employees and their spouses with serious mental illnesses and state employees whose children have been diagnosed with serious emotional disturbances . . . .").

122 *See id.* § 67-5761A (entitled, "Mental Health Parity in State Group Insurance").

123 *See id.* § 67-5761A(2)(a)(i)–(vii) (stating, "(a) 'Serious mental illness' means any of the following psychiatric illnesses as defined by the American psychiatric association in the diagnostic and statistical manual of mental disorders (DSM-IV-TR): (i) Schizophrenia; (ii) Paranoia and other psychotic disorders; (iii) Bipolar disorders (mixed, manic and depressive); (iv) Major depressive disorders (single episode or recurrent); (v) Schizoaffective disorders (bipolar or depressive); (vi) Panic disorders; and (vii) Obsessive-compulsive disorders").

protect state employees or spouses who have substance use disorders, eating disorders, intellectual or developmental disorders, or a range of other non-traditional mental health conditions. The Idaho law does protect children of state employees who have serious emotional disturbances,[124] defined as emotional or behavioral disorders, or neuropsychiatric conditions that result in serious disability, that require sustained treatment interventions and cause a child's functioning to be impaired in thought, perception, affect or behavior.[125] The Idaho law clarifies, however, that a child's substance abuse disorder does not, by itself, constitute a serious emotional disturbance, although a substance use disorder may coexist with a serious emotional disturbance.[126] In summary, the Idaho law establishes full mental health parity, but only for a limited class of people with a limited class of mental health conditions.

II. REFORMING STATE MENTAL HEALTH PARITY LAW

A. Conforming Changes Required by Federal Mental Health Parity Law

The original provisions of the Vermont, Maryland, Nevada, and Idaho laws discussed above were passed in 1997, 1994, 1999, and 2006, respectively. Over the past fifteen years, the federal government has played a role in regulating mental health insurance benefits, including through President Clinton's Mental Health Parity Act of 1996,[127] President George W. Bush's Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,[128]

---

124 *See* IDAHO CODE ANN. § 67-5761A(1) (applying the Idaho law to children of state employees who have serious emotional disturbances); *see also id.* § 67-5761A(2)(b) (internally referencing a separate definition of 'serious emotional disturbance'); *see also id.* § 16-2403(13) (defining 'serious emotional disturbance' under Idaho's Children's Mental Health Services Act).

125 *Id.* § 16-2403(13). A disorder results in a serious disability if it "causes substantial impairment of functioning in family, school or community." *Id.*

126 *Id.*

127 MHPA, *supra* note 33.

128 MHPAEA, *supra* note 34.

and President Obama's Patient Protection and Affordable Care Act of 2010.[129] Although some states, such as Nevada, have attempted to amend their state mental health parity laws to keep up with minimum federal requirements,[130] other states have not. I begin my reform of state mental health parity law by justifying and proposing amendments that would conform these and other state laws to minimum federal requirements.

The federal government took its first step towards mental health parity on September 26, 1996, when President Bill Clinton signed the Mental Health Parity Act (MHPA) into law.[131] MHPA regulates insured and self-insured group health plans of non-small employers, defined as those employers that employ an average of fifty-one or more employees.[132] MHPA is neither a mandated offer nor a mandated benefit law. The statute clarifies that it shall not be construed as requiring covered group plans to offer or provide any mental health benefits.[133] MHPA also is not a comprehensive parity law in that it does not regulate deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations imposed on mental health insurance benefits.[134] Finally, MHPA does not protect from insurance discrimination of individuals with substance use disorders.[135]

---

129 ACA, *supra* note 36.

130 *See, e.g.*, S.B. 426, § 37, 75th Leg., Reg. Sess. (Nev. 2009) (requiring group health plans and other health insurers in Nevada to comply with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations).

131 *See* MHPA, *supra* note 33.

132 *See id*. § 712(c)(1)(A)–(B) (exempting from 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.").

133 *See id*. § 712(b)(1).

134 *See id*. § 712(b)(2) (stating, "[n]othing 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 . . . .").

135 *See id*. § 712(e)(4) (stating, "[t]he 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

MHPA does, however, regulate lifetime and annual spending limits that are applied to non-substance use disorder mental health benefits by non-small group health plans, which already offer both mental health and physical health insurance benefits.[136] More specifically, if a covered group health plan does not impose an aggregate lifetime or annual limit on substantially all physical health benefits, the plan may not impose an aggregate lifetime or annual limit on offered mental health benefits.[137] If a covered group health plan does impose an aggregate lifetime or annual limit on substantially all physical health benefits, the plan shall either apply the applicable limit to both physical health and mental health benefits without distinguishing in the application of such limit between the two benefit sets, or the plan shall not impose any aggregate lifetime or annual limit on mental health benefits that is less than the applicable lifetime or annual limit imposed on physical health benefits.[138] MHPA thus would prohibit a covered group health plan from imposing a $20,000 annual cap or a $100,000 lifetime cap on mental health care if the plan had no annual or lifetime caps for physical health care or if the plan had higher caps, such as a $50,000 annual cap and a $500,000 lifetime cap, for physical health care.

Twelve years after President Clinton signed MHPA into law, President George W. Bush expanded the federal government's role in regulating mental health insurance benefits by signing into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[139] Like MHPA, MHPAEA regulates insured and self-insured group health plans of non-small employers, defined as those employers that employ an average of fifty-one or more employees, although an opt-out provision buried deep within the federal Public Health Service Act allows sponsors of self-funded, non-federal governmental plans to opt out of MHPAEA.[140] And, like MHPA, MHPAEA is neither a mandated offer

chemical dependency.").

136 *See* MHPA, *supra* note 33, § 712(a)(1)–(2).

137 *See id*. § 712(a)(1)(A); (no aggregate lifetime limits), § 712(a)(2)(A) (no annual limits).

138 *See id*. § 712(a)(1)(B); (aggregate lifetime limits), § 712(a)(2)(B) (annual limits).

139 *See* MHPAEA, *supra* note 34.

140 *See, e.g.*, Memorandum from Steve Larsen, Director of Oversight, Department of Health and

nor a mandated benefit law.[141] MHPAEA only regulates covered group health plans that already offer both physical and mental health benefits.[142]

MHPAEA builds on MHPA by protecting individuals with substance use disorders and by imposing comprehensive parity requirements on covered group health plans. In particular, MHPAEA requires financial requirements (including deductibles, copayments, coinsurance and other out-of-pocket expenses) [143] and treatment limitations (including inpatient day and outpatient visit limitations)[144] that covered group health plans impose on mental health and substance use disorder benefits to be no more restrictive than the predominant financial requirements and treatment limitations that are imposed on substantially all physical health benefits.[145] MHPAEA thus prohibits covered group health plans from

---

Human Services, Amendment to the HIPPA Opt-Out Provision (formerly Section 272(b)(2) of the Public Health Services Act) (Sept. 21, 2010) at 2, *available at* http://www.hhs.gov/ociio/regulations/opt_out_memo.pdf (discussing the ability of self-funded, non-federal governmental plans to opt out of federal mental health parity law and the survival of such ability post-ACA: "Provisions subject to opt-out for plan years beginning on or after 9/23/10 [include] . . . [p]arity in the application of certain limits to mental health benefits (including requirements of the Mental Health Parity and Addiction Equity Act)"); *see, e.g., The Mental Health Parity and Addiction Equity Act*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2010), http://www.cms.gov/healthinsreformforconsume/04_thementalparityact.asp (stating, "[a] nonfederal governmental employer that provides self-funded group health plan coverage to its employees (coverage that is not provided through an insurer) may elect to exempt its plan (opt-out) from the requirements of MHPAEA . . . . ").

141 *See* MHPAEA, *supra* note 34, § 512(a)(1) (regulating only those group health plans that offer both physical health and mental health benefits).

142 *See, e.g., The Mental Health Parity and Addiction Equity Act*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2010), http://www.cms.gov/healthinsreformforconsume/04_thementalparityact.asp (stating, "MHPAEA does not require large group health plans and their health insurance issuers to include MH/SUD [mental health and substance use disorder] benefits in their benefits package. The law's requirements apply only to large group health plans and their health insurance issuers that already include MH/SUD benefits in their benefit packages.").

143 *See* MHPAEA, *supra* note 34, § 512(a)(1)(B)(i) (including within the definition of "financial requirements" deductibles, copayments, coinsurance, and out-of-pocket expenses).

144 *See id.* § 512(a)(1)(B)(iii) (including within the definition of "treatment limitations" limits on the frequency of treatment, number of visits, days of coverage, and other similar limits on the scope or duration of treatment).

145 *See id.* § 512(a)(1)(A) (requiring both financial requirements and treatment limitations

imposing higher deductibles, copayments, or coinsurances on individuals who seek care for conditions such as bipolar disorder, schizophrenia, alcohol abuse, and drug abuse than the financial requirements imposed on individuals who seek physical health care, such as pregnancy and cancer care.[146] MHPAEA also prohibits covered group health plans from imposing lower (e.g., thirty or forty) inpatient day and outpatient visit limitations on individuals who require psychiatric care when individuals who require physical health care have a higher or unlimited number of covered inpatient days and outpatient visits.[147]

Two years after President Bush signed MHPAEA into law, President Obama further expanded the federal government's role in regulating mental health insurance benefits by signing into law the health care reform bill, formally known as the Patient Protection and Affordable Care Act (PPACA) and, one week later, a reconciliation bill, formally known as the Health Care and Education Reconciliation Act (HCERA) (collectively, the Affordable Care Act (ACA)).[148] Perhaps best known for its controversial (and constitutionally challenged) individual health insurance mandate,[149] ACA has several provisions buried deep within it that regulate mental health insurance benefits. The first provision relates to mandated mental health insurance benefits. Under ACA, "mental health and substance use disorder services, including behavioral health treatment[s]," must be part of the essential benefit package offered by certain health plans (including individual health plans, small group plans, and qualified

applicable to mental health and substance use disorder benefits to be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all physical health benefits covered by the plan).

146 *See id.*

147 *See id.*

148 ACA, *supra* note 36.

149 ACA, *supra* note 36, § 1501(b) (adding to the Internal Revenue Code: ''An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month."). On December 13, 2010, the Eastern District of Virginia declared unconstitutional ACA's minimum essential health insurance coverage requirement. *See* Commonwealth v. Sebelius, 728 F. Supp. 2d 768, 788 (E.D. Va. 2010). As of this writing, neither the Fourth Circuit Court of Appeals nor the United States Supreme Court has reviewed the District Court's opinion.

health plans, but not grandfathered health plans), and must be made available to certain individuals (including adults who are newly eligible for Medicaid and Basic Health coverage).[150] A grandfathered health plan is a group health plan or health insurance issuer that was in effect on March 23, 2010, the day President Obama signed PPACA into law.[151] Non-grandfathered health plans include group health plans and health insurance issuers established after March 23, 2010, as well as originally grandfathered health plans that subsequently lose grandfathered status.[152] The federal Department of Health and Human Services and two other federal agencies co-released an interim final rule on June 17, 2010, that identifies the activities that will and will not cause a grandfathered plan to lose grandfathered status.[153] Situations that will not cause a grandfathered plan to lose grandfathered status include: (i) the cessation of coverage by the plan of one or more or all of the individuals enrolled in the plan on March 23, 2010, so long as the plan has continuously covered someone since

---

150 *See* ACA, *supra* note 36, § 1302(b)(1)(E) ("[E]ssential health benefits . . . shall include . . . [m]ental health and substance use disorder services, including behavioral health treatment."); *id.* § 1201 ((adding new 42 U.S.C. § 300gg-6(a) (requiring health insurance issuers that offers health insurance coverage in the individual or small group markets to include the essential health benefits in such coverage); *id.* § 1301(a)(1)(B) (requiring qualified health plans to provide the essential health benefits package); *id.* § 2001(c) (requiring Medicaid benchmark benefit packages and benchmark equivalent coverage to provide at least the essential health benefits); 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. 34538, 34562 (June 17, 2010) [hereinafter Interim Final Grandfather Rules] (adding new 29 C.F.R. § 2590.715–1251(a), which defines "grandfathered health plan coverage" as "coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010."); *id.* at 34559 (explaining that Section 2707 of the Public Health Service Act does not apply to grandfathered health plans); *id.* at 34563 (adding new 29 C.F.R. § 2590.715-1251(c)(1) (stating, "[T]he provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans")); DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., *supra* note 37, at 1 (explaining that ACA's essential benefit package requirement is not applicable to grandfathered plans).

151 Interim Final Grandfather Rules, *supra* note 150, at 34562 (adding new 29 C.F.R. § 2590.715–1251(a)(1)(i), which defines 'grandfathered health plan coverage' as "coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010").

152 *Id.* at 34541 (defining grandfathered plans and identifying the ways in which grandfathered plans can lose grandfathered status, turning them into non-grandfathered plans).

153 *Id.* at 34538.

March 23, 2010; (ii) the enrollment of new family members in the plan after March 23, 2010, so long as the family members are dependents of an individual who was enrolled in the plan on March 23, 2010; (iii) the enrollment of newly hired employees and the enrollment of existing employees eligible for new enrollment after March 23, 2010;[154] and (iv) entering into a new policy, certificate or contract of insurance (that is, changing insurance carriers) after March 23, 2010.[155] Activities that will cause a grandfathered plan to lose grandfathered status include: (i) the elimination of all or substantially all benefits to diagnose or treat a particular condition; (ii) any increase in a percentage cost-sharing requirement; (iii) certain increases in fixed-amount cost-sharing requirements, including deductibles and out-of-pocket limits but not copayments; (iv) certain increases in fixed-amount copayments; (v) certain decreases in contribution rates by employers and employee organizations; and (vi) certain changes in annual limits.[156]

---

154 *Id.* at 34562–63 (adding new 29 C.F.R. § 2590.715-1251(a)(1)(i) (cessation of coverage by one or more or all insureds); *id.* § 2590.715-1251(a)(4) (addition of new family members); *id.* § 2590.715-1251(b)(1) (addition of newly hired or newly enrolled employees)). *See generally* BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., GRANDFATHERED HEALTH PLANS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 1 (Apr. 27, 2010) (hereinafter FERNANDEZ) (summarizing who is allowed coverage under a grandfathered health plan; explaining, "[c]urrent enrollees in grandfathered health plans are allowed to re-enroll in that plan, even if renewal occurs after date of enactment. Family members are allowed to enroll in the grandfathered plan, if such enrollment is permitted under the terms of the plan in effect on the date of enactment. For grandfathered group plans, new employees (and their families) may enroll in such plans").

155 Interim Final Grandfather Rules, *supra* note 150, at 34562 (adding new 29 C.F.R. § 2950.715-1251(a)(1)(ii) (stating, "if an employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010 . . . then that policy, certificate, or contract of insurance is not a grandfathered health plan with respect to the individuals in the group health plan")); *amended by* 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, 70121 (Nov. 17, 2010) (amending 29 C.F.R. § 2950.715-1251(a)(1)(i) to state: "[S]ubject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer.")).

156 Interim Final Grandfather Rules, *supra* note 150, at 34564–65 (adding new 29 C.F.R. § 2590.715–1251(g)(1) (listing the changes that will cause cessation of grandfathered status)).

Understanding the distinction between grandfathered and non-grandfathered plans is the key to understanding the application of ACA's health insurance reforms. Grandfathered health plans are exempt from the vast majority of new insurance reforms required by ACA,[157] including newly added Section 2707 of the Public Health Service Act, which requires health insurance issuers that offer health insurance coverage in the individual and small group markets to ensure that such coverage includes the essential health benefits package required under section 1302(a) of ACA.[158] Section 1302 of ACA includes within the definition of "essential health benefits" mental health and substance use disorder services, including behavioral health treatments.[159] As a result of these provisions, most non-grandfathered health plans will be required to provide mental health and substance use disorder benefits by January 1, 2014.[160] Stated another way, most non-grandfathered health plans must comply with ACA's mental health and substance use disorder mandated benefit when it goes into effect. Grandfathered health plans, on the other hand, continue to be regulated by the applicable provisions of MHPA and MHPAEA, neither of which contain a mandated mental health or substance use disorder benefit, as well as state law, which may or may not contain a mandated mental health and substance use disorder benefit.

---

157 *See, e.g., id.* at 34540 (explaining that ACA provides that certain group health plans and health insurance coverage existing as of March 23, 2010, are subject only to certain provisions of ACA); FERNANDEZ, *supra* note 154, at 1 (stating, "[g]randfathered health plans are exempt from the vast majority of new insurance reforms under PPACA.").

158 ACA, *supra* note 36, § 1201 (adding new 42 U.S.C. § 300gg-6(a) (codified at Section 2707(a) of the Public Health Service Act and stating, "[a] health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.")); Interim Final Grandfather Rules, *supra* note 150, at 34559 (explaining that Section 2707 of the Public Health Service Act does not apply to grandfathered health plans); *id.* at 34563 (adding new 29 C.F.R. 2590.715-1251(c)(1) (stating, "[T]he provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans.")); DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., *supra* note 37, at 1 (explaining that ACA's essential benefit package requirement is not applicable to grandfathered plans).

159 *See* ACA, *supra* note 36, § 1302(b)(1)(E) (stating, "essential health benefits . . . shall include . . . [m]ental health and substance use disorder services, including behavioral health treatment").

160 *See* FERNANDEZ, *supra* note 154, at 2.

A second buried ACA provision that is effective for plan years beginning on or after the date that is six months after March 23, 2010, provides: "Section 2726 of the Public Health Service Act [PHSA] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans."[161] Section 2726 of the PHSA is the parallel citation to 42 U.S.C. § 300gg-26, the section within the United States Code where MHPA as amended by MHPAEA is codified.[162] The dramatic effect of this second buried provision is to expand the application of MHPA and MHPAEA from just non-small group health plans to qualified health plans, including qualified individual health plans.[163] A third set of buried ACA provisions make conforming and technical changes to PHSA Section 2726 to clarify the expansion of MHPA and MHPAEA to individual health insurance coverage.[164] As a result of these additional buried provisions, many individual health plans that were previously exempt from MHPA and MHPAEA now are prohibited from offering inferior mental health insurance benefits, including higher deductibles, copayments, and coinsurance rates, as well as lower inpatient day and outpatient visit limitations. Even after ACA, however, note that neither MHPA nor MHPAEA requires grandfathered health plans to provide mental health benefits.[165] Thus, grandfathered health plans still will not be subject to any federal mental health or substance use disorder benefit mandates. Stated another way, grandfathered health plans may continue to refuse to provide benefits for mental illnesses and substance use

---

161 ACA, *supra* note 36, § 1311(j).

162 42 U.S.C. § 300gg-26 (2010) (entitled "Parity in Mental Health and Substance Use Disorder Benefits').

163 Compare MHPAEA, *supra* note 34, § 512(a)(1) (making its provisions applicable to "group health plan[s] or health insurance coverage offered in connection with such a plan") with 42 U.S.C. § 300gg-26(a)(1) (2010) (making its provisions applicable to a "group health plan or a health insurance issuer offering group or individual health insurance").

164 ACA, *supra* note 36, § 1562(c)(4) (identifying the conforming and technical changes that will be made to former 42 U.S.C. 300gg-5, and redesignating § 300gg-5 as § 300gg-26).

165 42 U.S.C. § 300gg-26(b)(1) (2010) ("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.").

disorders through policies and plans that provide coverage for traditional physical illnesses such as pregnancy and cancer unless state law requires otherwise.

The original provisions of the Vermont, Maryland, Nevada, and Idaho laws discussed above were passed in 1997, 1994, 1999, and 2006, respectively. Although some states, such as Nevada, have attempted to amend their state mental health parity laws to keep up with minimum federal requirements,[166] other states have not. The states are primarily responsible for regulating the insurance industry.[167] To the extent that a state enacted a mental health parity law prior to MHPA, MHPAEA, or ACA, or will be amending an old (or enacting a new) mental health parity law in the future, the state law will not be preempted by federal law so long as the state law does not prevent the application of federal law.[168] Because many states have mental health parity laws that are contrary to or less stringent than federal law, especially MHPAEA and ACA, I propose conforming changes to state mental health parity law. My proposals in this Section are based on: (i) illustrative Vermont, Maryland, Nevada, and Idaho statutory provisions; and (ii) the assumption of a continuing patchwork of state law; however, my proposal in Section III of a uniform state mental health parity law would do away with the need for the piecemeal, state-specific corrections discussed immediately below.

As discussed above, MHPA as amended by ACA regulates lifetime and annual spending limits that are applied to non-substance use disorder mental health benefits by non-small group health plans and individual health insurance plans that offer both mental health

---

166 *See, e.g.*, S.B. 426, § 37, 2009 Leg., 75th Reg. Sess. (Nev. 2009) (requiring group health plans and other health insurers in Nevada to comply with the provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations).

167 *See* 15 U.S.C. § 1012(a) ("The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.").

168 *See, e.g.*, FERNANDEZ, *supra* note 154, at 1 n.2 ("To the extent that states enacted health insurance standards and requirements prior to PPACA, or enact such standards and requirements after PPACA, such state laws would *not* be preempted by the federal health reform law as long as the state laws do not prevent the application of PPACA").

and physical health insurance benefits.[169] More specifically, MHPA prohibits covered health plans that do not impose an aggregate lifetime or annual limit on substantially all physical health benefits from imposing an aggregate lifetime or annual limit on mental health benefits.[170] If a covered group health plan does impose an aggregate lifetime or annual limit on substantially all physical health benefits, MHPA also requires the plan to either apply the applicable limit to both physical health and mental health benefits and not distinguish in the application of such limit between the two benefit sets; or, to not impose any aggregate lifetime or annual limit on mental health benefits that is less than the applicable lifetime or annual limit imposed on physical health benefits.[171] ACA built on MHPA by prohibiting group health plans and health insurance issuers offering group or individual health insurance coverage from establishing any lifetime as well as certain annual limits on the dollar value of essential health benefits for any participant or beneficiary.[172]

---

169 42 U.S.C. § 300gg-26(a)(1), (2).

170 *See id*. § 300gg-26(a)(1)(A) (no aggregate lifetime limits), § 300gg-26(a)(2)(A) (no annual limits).

171 *See id*. § 300gg-26(a)(1)(B) (aggregate lifetime limits), § 300gg-26(a)(2)(B) (annual limits).

172 ACA, *supra* note 36, § 1001 (adding new PHSA § 2711(a)). ACA prohibits lifetime dollar limits on essential benefits in any grandfathered or non-grandfathered health plan or insurance policy issued or renewed on or after September 23, 2010. 75 Fed. Reg. 37188, 37229–30. ACA restricts and phases out annual dollar limits that all grandfathered and non-grandfathered group health plans, as well as non-grandfathered individual health insurance plans issued after March 23, 2010, can place on essential benefits; that is, none of these plans can impose an annual dollar limit lower than: (i) $750,000 for a plan year or policy year starting on or after September 23, 2010 but before September 23, 2011; (ii) $1.25 million for a plan year or policy year starting on or after September 23, 2011 but before September 23, 2012; or (iii) $2 million for a plan year or policy year starting on or after September 23, 2012 but before January 1, 2014. *Id.* ACA prohibits annual limits on essential benefits beginning January 1, 2014. *See id.* at 37230 (adding new PHSA § 2711(a)(2) ("With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary."); 75 Fed. Reg. 37188, 37229–30 (June 28, 2010) (adding new lifetime and annual limit regulations at 29 C.F.R. § 2590.715-2711(a)–(d)). *See generally Eliminating Lifetime and Annual Limits on Your Benefits*, HEALTHCARE.GOV (Sept. 23, 2010) http://www.healthcare.gov/law/provisions/limits/limits.html (explaining the new lifetime and annual limit prohibitions and restrictions).

Although ACA reserves the right of a group health plan or health insurance coverage to impose "annual [and] lifetime per beneficiary limits on specific covered benefits," that are not essential health benefits,[173] "mental health and substance use disorder [benefits], including behavioral health treatment[s]," are considered essential health benefits[174] and, thus, are excepted from this right of reservation.

Neither Vermont, Maryland, nor Idaho imposes lifetime or annual limits on mental health or substance use disorder benefits. Nevada, however, requires the benefits provided by individual health insurance policies and small group health plans for treatment of alcohol or drug abuse to include: (i) a minimum benefit of $1,500 per calendar year for treatment for withdrawal from the physiological effect of alcohol or drugs; (ii) a minimum benefit of $9,000 per calendar year for treatment provided to a patient admitted as an inpatient to an alcohol or drug abuse facility; and (iii) a minimum benefit of $2,500 per calendar year for counseling for a person, group or family who is not admitted to an alcohol or drug abuse facility.[175] Nevada also requires most health plans in the state to offer a minimum benefit of $36,000 per year for applied behavioral analysis treatment for individuals with autism spectrum disorders.[176] To the extent that Nevada law may be read as allowing an individual health insurance policy or small group health plan to impose an annual cap that is higher than the minimum benefit, such as $1,501, $9,001, or $2,501 on withdrawal care, inpatient care, and counseling care, respectively, or that is higher than the minimum offer, such as $36,001, required for applied behavioral analysis for treatment of an autism spectrum disorder, the Nevada law should be revised to clarify that all lifetime caps on mental health and substance use disorder benefits, including behavioral health treatments, are now prohibited, and to clarify that most annual caps are being phased out and will be prohibited by January 1, 2014. Again, although ACA

---

173 ACA, *supra* note 36, § 1001 (adding new PHSA § 2711(b)).

174 *Id.* § 1302(b)(1)(E) (including "[m]ental health and substance use disorder services, including behavioral health treatment," within the definition of essential health benefits).

175 NEV. REV. STAT. ANN. § 689A.046(1)(a)–(c) (LexisNexis 2009); *id.* § 689C.167(1)(a)–(c).

176 *See, e.g., id.* § 689A.0435(2)(a).

reserves the right of a group health plan or health insurance coverage to impose annual and lifetime per beneficiary limits on specific covered benefits that are not essential health benefits, [177] mental health and substance use disorder benefits, including behavioral health treatments, are considered essential benefits[178] and thus are excepted from this right of reservation.

As discussed above, MHPAEA requires that non-small group health plans impose no more restrictive financial requirements (including deductibles, copayments, and coinsurance)[179] and treatment limitations (including inpatient day and outpatient visit limitations)[180] on mental health and substance use disorder benefits than are imposed on substantially all physical health benefits.[181] ACA expands the category of health plans covered by MHPAEA from just non-small group health plans to qualified health plans.[182]

As a result, any state law that permits non-small group health plans and qualified health plans to impose more restrictive financial requirements and treatment limitations on mental health service use are contrary to or less stringent than MHPAEA and ACA and should be reformed. Idaho, for example, only requires mental health parity in the context of state group health coverage provided to state employees and their family members.[183] Idaho's parity provisions

---

177 ACA, *supra* note 36, § 1001 (adding new PHSA § 2711(b)).

178 *Id.* § 1302(b)(1)(E) (including "[m]ental health and substance use disorder services, including behavioral health treatment," within the definition of essential health benefits).

179 MHPAEA, *supra* note 34, § 512(a)(1) (including within the definition of 'financial requirements' "deductibles, copayments, coinsurance, and out-of-pocket expenses").

180 *See id.* § 512(a)(1) (including within the definition of 'treatment limitations' "limits on the frequency of treatment, number of visits, days of coverage, and other similar limits on the scope or duration of treatment").

181 *See id.* § 512(a)(1) (requiring both financial requirements and treatment limitations applicable to mental health and substance use disorder benefits to be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all physical health benefits covered by the plan).

182 *Compare, e.g.* MHPAEA, *supra* note 34, § 512(a)(1) (making its provisions applicable to "group health plans or health insurance coverage offered in connection with such a plan") *with, e.g.* 42 U.S.C. § 300gg-26 (2010) (making its provisions applicable to a "group health plan or a health insurance issuer offering group or individual health insurance").

183 IDAHO CODE ANN. § 67-5761A(1) (2006).

thus should be expanded to include non-state, non-small group health plan coverage as well as qualified health plans. In addition, the parity provisions of both Nevada and Idaho are limited to six and seven serious mental illnesses, respectively.[184] Idaho also clarifies that a child's substance use disorder, by itself, is not protected by the Idaho law.[185] MHPAEA's and ACA'S parity provisions, on the other hand, protect individuals who have any generally recognized mental illness or substance use disorder, including any one of the dozens of disorders that are identified in the Diagnostic and Statistical Manual of Mental Disorders or the ICD.[186] Nevada's and Idaho's parity provisions should be expanded to reference the current edition of the DSM, ICD, or any other generally recognized mental illness and substance use disorder classification manual, and should specifically apply parity rules to both traditional mental illnesses as well as substance use disorders and other mental disorders listed in the DSM, ICD, or other generally recognized classification manual.

Neither Maryland's nor Nevada's parity provisions are as stringent as those set forth in the MHPAEA. For example, Maryland permits health insurance policies and contracts to cover only sixty days of partial hospitalization for mental illnesses even if such contracts cover more than sixty days of partial hospitalization for individuals with physical illnesses.[187] In addition, Maryland permits individual health plans and group contracts covering employees of

---

184 *Id.* § 67-5761A(2)(a)(i)–(vii); NEV. REV. STAT. ANN. § 689A.0455(8)(a)–(f).

185 IDAHO CODE ANN. § 16-2403(13) (2009).

186 *See, e.g.*, Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5412 (Feb. 2, 2010) (to be codified at 45 C.F.R. pt. 146) (stating, "These regulations further provide that the plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice. This requirement is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements. . . . For example, a plan may follow the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or a State guideline. All of these would be considered acceptable resources to determine whether benefits for a particular condition are classified as medical/surgical, mental health, or substance use disorder benefits.").

187 MD. CODE ANN., INS. § 15-802(d)(2) (LexisNexis 2010).

small employers[188] to impose increasing coinsurance amounts on insureds for outpatient services provided to treat mental illness and substance use disorders, including a 20% coinsurance for the first five visits in a calendar year or benefit period of not more than twelve months, a 35% coinsurance for the sixth through thirtieth visit in the same year or period, and a 50% coinsurance for the thirty-first visit and any subsequent visits in the same year or period.[189] Maryland law should be revised to require non-small group health plans and qualified health plans to establish complete parity between physical and mental health benefits in all rates, terms, and conditions, including inpatient day limitations, outpatient visit limitations, and coinsurance amounts.

Similar to Maryland law, Nevada law permits individual health insurance policies and small group health plans to cover only forty inpatient days and forty outpatient visits for treatment of severe mental illnesses, and to impose 150% higher deductibles, copayments, and other out-of-pocket expenses on mental health care service usage.[190] Nevada law should be revised to require qualified health plans to establish complete parity between physical and mental health benefits in all rates, terms, and conditions, including inpatient day limitations, outpatient visit limitations, and coinsurance amounts.

Nevada law does not require large group health plans and other health insurers to offer or provide any mental health or substance use disorder benefits. If a large group health plan or other insurer does offer mental health or substance use disorder benefits, Nevada law (by reference to MHPAEA) requires such benefits to not be more restrictive than their physical benefit counterparts in terms of deductibles, copayments, coinsurance, inpatient day limitations, outpatient visit limitations, and other financial requirements and

---

188 *Id*. § 15-1203(b)(1) (defining small employer as an employer that employs "at least two but not more than 50 eligible employees, the majority of whom are employed in the State").

189 *See id*. § 15-802(d)(4)(i)–(iii) (allowing the imposition of the increasing coinsurance amounts); *id*. § 15-802(d)(5) (prohibiting group contracts covering employees of one or more large employers from imposing the increasing coinsurance amounts).

190 NEV. REV. STAT. § 689A.0455(a)(1), (2), (3) (2010); *id*. § 689C.169(2)(a)(1), (2), (3) (2010).

treatment limitations.[191] Nevada law should be revised to clarify that non-grandfathered individual and small group health plans must include the essential health benefits package required under section 1302(a) of ACA,[192] including mental health, benefits, substance use disorder benefits, and behavioral treatment benefits.[193]

B. Expanding the Application of State Mental Health Parity Law

As I explained in my introduction, this Article is the third and final installment in a three-part project that presents a comprehensive challenge to lingering legal distinctions between physical and mental illness in the context of health insurance. The second installment challenged a number of federal provisions, including Medicare and Medicaid provisions, which allow public health care programs to provide mental health insurance benefits that are less comprehensive than their physical counterparts.[194] In the second installment, I proposed comprehensive federal reforms, including the extension of mental health parity to individuals who do not currently benefit from

---

191 S.B. 426, § 37, 2006 Leg. 75th Reg. Sess. (Nev. 2009) (stating, "An insurer or other organization providing health coverage pursuant to chapter 689B, 695A, 695B, 695C or 695F of NRS shall comply with the provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 . . . and any federal regulations issued pursuant thereto").

192 ACA, *supra* note 36, § 1201 (adding new Section 2707(a) to the Public Health Service Act and stating, "A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act")(codified as amended at 42 U.S.C. § 300gg-6(a)); Interim Final Grandfather Rules, *supra* note 150, at 34559 (explaining that Section 2707 of the Public Health Service Act does not apply to grandfathered health plans); *id*. at 34563 ("[T]he provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans")); EMP. BENEFITS SEC. ADMIN., DEP'T OF LABOR, APPLICATION OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS ACT TO GRANDFATHERED PLANS 1 (2010), *available at* www.dol.gov/ebsa/pdf/grandfatherregtable.pdf (explaining that ACA's essential benefit package requirement is not applicable to grandfathered plans).

193 *See* ACA, *supra* note 36, § 1302(b)(1)(E) (stating, "essential health benefits . . . shall include . . . [m]ental health and substance use disorder services, including behavioral health treatment").

194 *See* Tovino, *supra* note 2.

mental health parity law.[195]

To justify these comprehensive reforms, I thoroughly analyzed reasons provided by public health care programs and private health insurers for providing inferior insurance benefits to individuals with mental illness, including allegations that mental health care is more costly and less efficacious than physical health care and that individuals with mental illness have a greater role in, and responsibility for, their lack of health.[196] I found, however, that these reasons are not supported in the relevant clinical, economic, social, and criminal literatures.[197] For example, notwithstanding insurers' claims that treating mental illness will result in prohibitive insurance delivery cost increases, I found that mental health parity implementation has an upward effect on cost that is either "minimal" or "negligible" and, when combined with managed mental health care, may produce a downward effect on mental health care costs or total health care costs as well as clinical and economic returns on the initial treatment investment.[198] Notwithstanding insurers' claims that mental illness is too difficult to diagnose and treat relative to physical illness, I found that mental illnesses, on average, are just as easily diagnosed and treated as are physical illnesses.[199] Notwithstanding judicial attempts in the context of health insurance coverage litigation to distinguish physical and mental illnesses based on tests that inquire into the area of specialization of the treating health care provider, the nature and type of treatment provided, the origin of the illness, and the symptoms of the illness, I found that not one of these tests provides a rational, consistent method of distinguishing physical and mental illness.[200]

Also in the second installment of this project, I inquired into the economic implications of untreated mental illness and found that individuals with untreated mental illness have not only higher total

---

195 *See id.*

196 *See id.*

197 *See id.*

198 *See* Tovino, *supra* note 2.

199 *See id.*

200 *See id.*

health care costs, but also lower rates of work productivity, higher rates of disability, higher rates of homelessness and welfare receipt, and higher rates of criminal activity, suggesting a significant societal return on investment associated with treating mental illness.[201] I further examined other health-related laws outside the pure health insurance context, including disability discrimination law, civil rights and human rights law, health information confidentiality law, health care reform law, and child and adult health and welfare law; I found that not one of these laws provides inferior legal protections or benefits for individuals with mental illness.[202] Finally, I analyzed international, national, state, and professional definitions of health that are used in a range of clinical, legal, and social contexts and found that these definitions uniformly failed to subordinate mental health to physical health and that these definitions identified both physical wellness and mental wellness as equal contributors to overall health.[203]

As I explained in the introduction to my second installment, my aim with this three-part project has been to bring greater attention to the origins and evolution of the concept of health and to discredit the notion that individuals with mental health conditions are less deserving of legal protection and benefits than individuals with physical health conditions.[204] The findings I presented in my second installment are relevant not just to federal mental health parity reform but also to state mental health parity reform, the focus of this Article. Without repeating these findings, I incorporate them in this third and final installment in order to justify the state mental health parity reforms proposed below.

In the previous section, I assumed a continuing patchwork of state law and identified illustrative, but certainly not exhaustive, state-specific reforms that could be adopted by legislatures of states with particular mental health parity weaknesses. In the following sections, I would like to think more broadly and propose the

---

201 *See id.*

202 *See id.*

203 *See* Tovino, *supra* note 2.

204 *See id.*

expansion of mental health parity law to: (i) regulate all health plans that are subject to state regulation; (ii) mandate the inclusion of mental health and substance use disorder benefits in all such health plans; and (iii) protect individuals with all psychiatric, neurological, substance abuse, intellectual, and developmental disorders and disabilities, not just those currently labeled as "biologically-based disorders" or "severe mental illnesses."

Many state mental health parity laws only regulate one or two classes of health plans, leaving other health plans to offer inferior or no mental health insurance benefits. The Idaho law, for example, only regulates state group health coverage, but not non-state individual or group health coverage.[205] Because research does not show higher costs associated with mental health parity implementation in some categories of health plans,[206] such as individual health plans or small group health plans, and because research suggests that all health plans may maintain or lower total health care costs by treating members' mental illnesses, I argue that state mental health parity laws should be applied to all insured health plans. I thus propose that all state mental health parity laws regulate all health insurance issuers, individual health plans, insured small group health plans, insured large group health plans, health maintenance organizations, other managed care plans, and nonprofit hospital and medical service corporations. The Vermont law, which broadly regulates all health care programs and plans, may be used as a model.[207] The uniform state mental health parity law I propose in Section III would regulate all insured health plans and health insurance coverage due to its use of the phrase "all insured health plans and health insurance coverage" in proposed statutory sections 1 through 4 and the broad definition of "health plan and health insurance coverage" in section

---

205 *See* IDAHO CODE ANN. § 67-5761A (West 2009).

206 *See* Tovino, *supra* note 2, at Part I-B.

207 *See* VT. STAT. ANN. tit. 8, § 4089b(b)(1) (2010) (regulating all health insurance plans, including any health insurance policy or health benefit plan offered by a health insurer as well as any health benefit plan offered or administered by the State of Vermont or any subdivision thereof); VT. STAT. ANN. tit. 18, § 9402(8) (Supp. 2010) (defining 'health insurer' to include health insurance companies, nonprofit hospital and medical service corporations, and managed care organizations, as well as the administrators of insured, self-insured, and publicly funded health care benefit plans offered by public and private entities).

5(d).

Because research does not show higher costs associated with mental health parity laws that contain mandated mental health and substance use disorder benefit provisions (compared to mental health parity laws with mandated offer provisions and compared to mental health parity laws that require neither the provision nor offer of mental health and substance use disorder benefits),[208] I argue that all state mental health parity laws should contain a mandated mental health and substance use disorder benefit. Under ACA, most non-grandfathered health plans are required to include mental health and substance use disorder benefits, including behavioral treatments, in their essential benefit packages.[209] My proposal would extend ACA to grandfathered health plans as well. The Vermont and Maryland laws, both of which contain mandated mental health and substance use disorder benefits, may be used as models.[210] The uniform state mental health parity law I propose in Section III contains a mandated mental health and substance use disorder benefit in proposed section 1: "All health plans and health insurance coverage shall provide mental health and substance use disorder benefits."

Many state mental health parity laws contain distinctions between biologically-based and non-biologically based mental disorders, and/or between severe and non-severe mental illnesses, and only protect individuals with biologically-based mental disorders or severe mental illnesses from insurance discrimination. Nevada, for example, provides mental health parity only to individuals with six mental illnesses that Nevada believes are biologically-based and, therefore, severe: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder.[211] Idaho, by

---

208 *See* Tovino, *supra* note 2, at Part I-B.

209 ACA, *supra* note 36, at § 1302.

210 *See supra* text accompanying notes 38 (Vermont) and 56 (Maryland).

211 NEV. REV. STAT. ANN. § 689A.0455(8)(a)–(f) (2009) (stating, "'severe mental illness' means any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association: (a) Schizophrenia; (b) Schizoaffective disorder; (c) Bipolar disorder; (d) Major depressive disorders; (e) Panic

further example, only requires parity for state employees and spouses who have one of seven "serious mental illnesses," defined to include schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, schizoaffective disorders, panic disorders, and obsessive-compulsive disorders.[212] Over the last several years, I have authored a number of articles that have reported recent developments in neuroscience and have identified and examined the implications of these developments for a range of civil, regulatory, and criminal health law issues.[213] A recurring theme in all of these articles is the extent to which scientists conducting structural and functional neuroimaging studies are reporting a basis in neurobiology—usually identified as a neurobiological correlate but sometimes stated or suggested as a neurobiological cause or neurobiological consequence—of not only traditional neurological and psychiatric illnesses but also substance use disorders, intellectual and developmental disabilities, and other behaviors, characteristics, traits, tastes, and preferences. In a 2007 article, I examined how structural and functional neuroimaging

---

disorder; and (f) Obsessive-compulsive disorder").

212 *See* IDAHO CODE ANN. § 67-5761A(2)(a)(i)–(vii) (West 2009) (stating, "'Serious mental illness' means any of the following psychiatric illnesses as defined by the American psychiatric association in the diagnostic and statistical manual of mental disorders (DSM-IV-TR): (i) Schizophrenia; (ii) Paranoia and other psychotic disorders; (iii) Bipolar disorders (mixed, manic and depressive); (iv) Major depressive disorders (single episode or recurrent); (v) Schizoaffective disorders (bipolar or depressive); (vi) Panic disorders; and (vii) Obsessive-compulsive disorders.").

213 *See, e.g.*, Stacey A. Tovino, *Women's Neuroethics*, *in* OXFORD HANDBOOK OF NEUROETHICS (Judy Illes & Barbara Sahakian eds., Oxford University Press forthcoming 2011); Stacey A. Tovino, *Medico-Legal Issues in Neuroimaging*, *in* NEUROETHICS IN PRACTICE (Martha Farah & Anjan Chatterjee eds., Oxford University Press forthcoming 2010); Stacey A. Tovino, *Scientific Understandings of Postpartum Illness: Improving Health Law and Policy?*, 33 HARVARD J.L. & GENDER 99 (2010); Stacey A. Tovino, *Remarks: Neuroscience, Gender, and the Law*, 42 AKRON L. REV. 941 (2009); Stacey A. Tovino, *Neuroscience and Health Law: An Integrative Approach?*, 42 AKRON L. REV. 469 (2009); Stacey A. Tovino, *Incidental Findings: A Common Law Approach*, 15 ACCOUNTABILITY RES. 242 (2008); Stacey A. Tovino, *Neuroimaging Research into Disorders of Consciousness: Moral Imperative or Legal and Ethics Failure?*, 13 VA. J. L. & TECH., Winter 2008 at 1 (2008); Stacey A. Tovino, *The Impact of Neuroscience on Health Law*, 1(2) NEUROETHICS 73 (2008); Stacey A. Tovino, *Functional Neuroimaging Information: A Case for Neuro Exceptionalism?*, 34 FLA. ST. U. L. REV. 415 (2007); Stacey A. Tovino, *Imaging Body Structure and Mapping Brain Function: A Historical Approach*, 33 AM. J. L. & MED. 193 (2007); Stacey A. Tovino, Functional *Neuroimaging and the Law: Trends and Directions for Future Scholarship*, AM. J. BIOETHICS-NEUROSCIENCE, Sept. 2007, at 44.

technology has been used by scientists to identify neurobiological correlates of a range of traditional and non-traditional physical and mental health conditions (including physical pain, migraines, cluster headaches, stroke, multiple sclerosis, Parkinson's disease, Alzheimer's disease, major depression, bipolar disorder, schizophrenia, obsessive-compulsive disorder, dyslexia, hyperlexia, attention-deficit/hyperactivity disorder, pedophilia, cocaine addiction, compulsive gambling, and obesity), as well as a range of personal behaviors, characteristics, traits, tastes, and preferences (including racial evaluation, deception, social cooperation, altruism, sexual arousal, love, ethical decision making, expected and unexpected pleasure, satiety, anxiety, neuroticism, extraversion, self-consciousness, social rejection, intelligence, humanity, empathy (or lack thereof), trust, humor, and recognition of beauty).[214] Current science shows that almost all mental health conditions and substance use disorders have been reported by scientists to have some type of basis in neurobiology, such as a neurobiological cause, correlate, or consequence, and state laws such as Nevada's that identify only six traditional mental illnesses as having a basis in biology are outdated and unsupported in the current neuroscientific literature.[215] For example, state legislatures rarely include pedophilia, eating disorders, and autism in definitions of "biologically-based mental disorders," even though recent scientific studies suggest that all three of these conditions may have neurobiological correlates[216] and,

---

214 *See* Stacey A. Tovino, *Functional Neuroimaging Information: A Case for Neuro Exceptionalism?* 34 FLA. ST. U. L. REV. 415, 423–442 (2007).

215 *See* NEV. REV. STAT. ANN. § 689A.0455(8)(a)–(f) (2009).

216 *See, e.g.*, M. Walter et al., *Pedophilia Is Linked to Reduced Activation in Hypothalamus and Lateral Prefrontal Cortex During Visual Erotic Stimulation*, 15 BIOLOGICAL PSYCHIATRY 698–99, (2007) (reporting neurofunctional correlates of pedophilia); B. Schiffer et al., *Functional Brain Correlates of Heterosexual Paedophilia*, 41 NEUROIMAGE 80, 80–91 (2008) (reporting neurofunctional correlates of heterosexual pedophilia); E.K. Lambe et al., *Cerebral Gray Matter Volume Deficits after Weight Recovery from Anorexia Nervosa*, 54 ARCHIVES GEN. PSYCHIATRY 537 (1997) (reporting neuroanatomical correlates of recovery from anorexia nervosa); M. Mühlau et al., *Gray Matter Decrease in the Anterior Cingulate Cortex in Anorexia Nervosa*, 164 AM. J. PSYCHIATRY 1850 (2007) (reporting neuroanatomical correlates of anorexia nervosa); Angela Wagner et al., *Altered Reward Processing in Women Recovered from Anorexia Nervosa*, 164 AM. J. PSYCHIATRY 1842 (2007) (reporting neurofunctional correlates of recovery from anorexia nervosa); Daniel P. Kennedy, *Neural Correlates of Autistic Traits in the General Population: Insights into Autism*, 166 AM. J. PSYCHIATRY 849, 849–51 (2009) (referring

perhaps, that these and other less popular mental disorders should be classified as "biologically-based."

I thus argue that states should delete outdated distinctions between biologically-based and non-biologically based mental disorders and amend their mental health parity laws to protect all individuals with psychiatric, neurological, substance abuse, intellectual and developmental disorders. The Vermont law, which defines the phrase "mental health condition" to include all mental illnesses listed in the mental disorders section of the current edition of the International Classification of Disease (ICD),[217] may be used as a model. The uniform state mental health parity law I propose in Section III would protect individuals with any condition listed in the mental disorder section of the ICD through a broad definition of "mental health and substance use disorder benefits" in my proposed section 5(f).

Finally, I argue that states need to revisit distinctions between severe and non-severe mental illnesses. With respect to state mental health parity laws that only protect individuals with severe or serious mental illnesses,[218] it is not clear how the illnesses chosen for severe or serious status were selected. Although few would doubt that

---

to scientific studies investigating the neural correlates of autistic traits); Nicole Schmitz et al., *Neural Correlates of Executive Function in Autistic Spectrum Disorders*, 59 BIOLOGICAL PSYCHIATRY 7, 7–16 (2006) (reporting neurofunctional correlates of autism spectrum disorders).

217 VT. STAT. ANN. tit. 8, § 4089b(b)(2) (2011) (stating, "'[m]ental health condition' means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised"); *see also* ICD-10, *supra* note 44 (including a broad range of mental and behavioral disorders in Chapter V).

218 *See, e.g.*, NEV. REV. STAT. § 689A.0455(8)(a)–(f) (2009) (stating, "'severe mental illness' means any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association: (a) Schizophrenia[;] (b) Schizoaffective disorder[;] (c) Bipolar disorder[;] (d) Major depressive disorders[;] (e) Panic disorder[;] and (f) Obsessive-compulsive disorder."); IDAHO CODE § 67-5761A(2)(i)–(vii) (stating, "'Serious mental illness' means any of the following psychiatric illnesses as defined by the American psychiatric association in the diagnostic and statistical manual of mental disorders (DSM-IV-TR): (i) Schizophrenia; (ii) Paranoia and other psychotic disorders; (iii) Bipolar disorders (mixed, manic and depressive); (iv) Major depressive disorders (single episode or recurrent); (v) Schizoaffective disorders (bipolar or depressive); (vi) Panic disorders; and (vii) Obsessive-compulsive disorders").

bipolar disorder, schizophrenia, and obsessive-compulsive disorder are severe in nature, dozens of other illnesses and disorders including, but certainly not limited to, adolescent and adult alcohol and drug abuse, soldiers' post-traumatic stress disorder, and children's autism are equally disabling. The uniform state mental health parity law I propose in Section III contains neither distinctions between biologically-based and non-biologically based mental disorders nor distinctions between severe and non-severe mental illnesses.

III. PROPOSAL: A UNIFORM STATE MENTAL HEALTH PARITY LAW

In order to implement the proposals outlined in Section II, I offer for consideration by state legislatures the following uniform state mental health parity law entitled, "Parity in Mental Health and Substance Use Disorder Benefits." Section 1 contains a mandated mental health and substance use disorder benefit. Sections 2 and 3 prohibit lifetime and annual limits imposed on mental health and substance use disorder benefits. Section 4 requires the implementation of full parity in all mental health and substance use disorder benefit rates, terms, and conditions. Section 5 defines relevant terms. As I explained in the second installment of this series, I do not anticipate that mental health parity implementation will increase total health care costs.[219] Should the dynamics of mental health economics change in a way that would cause mental health parity implementation to be associated with prohibitive cost increases. Section 6 contains a cost exemption on which health plans and health insurance issuers may rely. Section 6 also contains a sunset provision that will cause Section 6 to be removed from the legislation after five years if no health plan or health insurance issuer in the state has obtained a cost exemption.

---

219 *See* Tovino, *supra* note 2, § I(B).

Parity in Mental Health and Substance Use Disorder Benefits

1. Mandated mental health and substance use disorder benefits. All health plans and health insurance coverage shall provide mental health and substance use disorder benefits.

2. No aggregate lifetime limits. A health plan or health insurance coverage shall not impose an aggregate lifetime limit on mental health or substance use disorder benefits.

3. No annual limits. A health plan or health insurance coverage shall not impose an annual limit on mental health or substance use disorder benefits.

4. Financial requirements and treatment limitations. In the case of any health plan or health insurance coverage, such plan or coverage shall ensure that (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

5. Definitions. In this section, the following terms shall have the following meanings:

a. Aggregate lifetime limit. The term "aggregate lifetime limit" means, with respect to benefits under a health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

b. Annual limit. The term "annual limit" means, with respect to benefits under a health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

c. Financial requirement. The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but

excludes an aggregate lifetime limit and an annual limit subject to paragraphs 2 and 3.

d. Health plan and health insurance coverage. The terms "health plan and health insurance coverage" and "plan and coverage" include all health insurance carriers and insured health plans including, but not limited to, health insurance issuers, individual health plans, insured small group health plans, insured large group health plans, health maintenance organizations, other managed care plans, and nonprofit hospital and medical service corporations.

e. Medical or surgical benefits. The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health or substance use disorder benefits.

f. Mental health and substance use disorder benefits. The term "mental health and substance use disorder benefits" means benefits with respect to services provided for treatment of any condition listed in the mental disorder section of the current edition of the World Health Organization's International Classification of Disease (ICD) Manual.

g. Predominant. The term "predominant" means, with respect to a financial requirement or treatment limitation, that the financial requirement or treatment limitation is the most common or frequent of such type of limit or requirement.

h. Treatment limitation. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

6. Cost exemption.

In general. If the application of Sections 1 through 4 results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under Section 6(c)) by an amount that exceeds the applicable percentage described in Section 6(b) of the actual total plan costs, the provisions of this law shall not apply to such plan or coverage during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. A plan or coverage may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the plan or coverage involved regardless of any increase in total costs.

Applicable percentage. With respect to a plan or coverage, the applicable

percentage described in this Section 6(b) shall be— (i) 2 percent in the case of the first plan year in which this section is applied; and (ii) 1 percent in the case of each subsequent plan year.

Determinations by actuaries. Determinations as to increases in actual costs under a plan or coverage for purposes of this law shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the plan or health insurance issuer for a period of 6 years following the notifications made under Section 6(e).

Six-month determinations. If a plan or coverage seeks an exemption under Section 6, determinations under Section 6(a) shall be made after such plan or coverage has complied with this law for the first 6 months of the plan year involved.

Notifications.

In general. A plan or coverage that, based upon a certification described under Section 6(c), qualifies for an exemption under this law, and elects to implement the exemption, shall promptly notify the Secretary of the state's Department of Health and Human Services as well as the participants and beneficiaries in the plan of such election.

Requirement. A notification to the State Secretary under clause (i) shall include— (I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage); (II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and (III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

Sunset. The cost exemption identified in this Section 6 shall expire 5 years after the date of enactment if no health plan or health insurance issuer in the state has obtained a cost exemption within five years of the date of enactment.