

2012

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Recommended Citation

Tovino, Stacey A., "Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits" (2012). *Scholarly Works*. 687.

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Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits

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

This Article provides further support for my recent proposal to extend federal mental health parity law and mandatory mental health and substance use disorder benefits to all public healthcare program beneficiaries and private health plan members.¹ In my recent proposal, I analyzed justifications provided by public healthcare programs and private health insurers for providing inferior insurance benefits² for 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.³ I found that these reasons were not supported in the current clinical, economic, and social literatures. More specifically, I found that the current health plan cost literature shows that untreated mental illness is associated with increases in total healthcare costs and that treatment of mental illness is associated with decreases in total healthcare costs.⁴ I further found that the current mental health economics literature shows that managed behavioral health care significantly reduces if not eliminates the problem of moral hazard in the context of mental health care.⁵ Recent

* 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 his financial support of this research project. I also thank Jeanne Price (Director, Wiener-Rogers Law Library), Chad Schatzle (Reference Librarian, Wiener-Rogers Law Library), and Michael Vargas (former student at Boyd School of Law) for their outstanding assistance in locating many of the sources referenced in this Article. I further thank the participants of the following symposia and meetings for their helpful comments and suggestions on earlier drafts of this Article: The 34th Annual Health Law Professors Conference sponsored by the American Society for Law, Medicine & Ethics and the Loyola University Chicago School of Law; The 26th Annual Whittier Health Law Symposium of Whittier Law School; and The 64th Annual Meeting of the Southeastern Association for Law Schools.

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

2. See *id.* at Section I(A) (summarizing the historically inferior mental health insurance benefits provided by public health care programs and private health plans).

3. See *id.* at Section I(B).

4. See *id.*

5. See *id.*

studies of cost data obtained from healthcare delivery settings in which mental health parity has been implemented show that mental health parity implementation has not increased total health care delivery costs in those settings.⁶ Recent studies of the relationship between untreated mental illness and other variables, including employment, disability, homelessness, welfare, and crime, show that individuals with untreated mental illness have not only higher total health care costs, but also lower rates of work productivity, higher rates of disability, higher rates of homelessness, higher rates of welfare, and higher rates of criminal activity, suggesting significant employer and public program returns on initial mental health treatment investments.⁷ Notwithstanding insurers' claims that mental illness is too difficult to diagnose and treat relative to physical illness, I also found that the current medical and scientific literature shows that mental illnesses, on average, are as easily diagnosed and treated as are physical illnesses.⁸ Despite judicial attempts in the context of health insurance coverage litigation to distinguish physical and mental illnesses based on a number of different tests that inquire into the area of specialization of the treating healthcare provider, the nature and type of treatment, and the origin and symptoms of the illness, I found that not one of these tests provides a rational or consistent method of distinguishing physical and mental illness.⁹

In this Article, I would like to provide additional support for my proposal to extend federal mental health parity law and mandatory mental health and substance use disorder benefits to all public healthcare program beneficiaries and private health plan members. I begin by examining health-related doctrine outside the context of mental health insurance law, including disability discrimination law, civil rights and human rights law, health information confidentiality law, healthcare reform law, and child and adult health and welfare law, and I find that not one of these laws provides inferior legal protections or benefits for individuals with mental illness. I also analyze international, national, state, and professional definitions of "health" that are used in a range of clinical, legal, and social contexts and find that these definitions uniformly fail to subordinate mental health to physical health and that these definitions identify both physical wellness and mental wellness as equal contributors to overall health. I further suggest that remaining legal distinctions between physical and mental illness may emanate from the centuries-old mind-body problem, which continues to animate health law, philosophy of the mind, and other legal and philosophical doctrine. Finally, I suggest that the stigma associated with

6. *See id.*

7. *See id.*

8. *See id.* at Section I(D).

9. *See id.* at Section I(E).

mental illness may be serving as a final – and perhaps the most formidable – obstacle to complete mental health parity.

I. MENTAL ILLNESS IN OTHER LEGAL CONTEXTS

In light of current federal mental health insurance law, which continues to allow some public healthcare program beneficiaries and private health plan members to be subject to mental health benefit disparities,¹⁰ I wanted to investigate whether other health-related laws continue to allow discrimination against individuals with mental illness and, if so, to explore the justifications provided for such discrimination. I thus examine disability discrimination law, civil rights and human rights law, health information confidentiality law, healthcare reform law, and child and adult health and welfare law and find that not one of these areas of law provides inferior legal protections or benefits for individuals with mental illness.

Federal disability discrimination law, including the Americans with Disabilities Act of 1990 (“ADA”)¹¹ as amended by the ADA Amendments Act of 2008 (“ADAAA”),¹² equally protects from disability discrimination individuals with physical disabilities and individuals with mental disabilities. President George H.W. Bush signed the ADA into law on July 26, 1990, to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.¹³ The original ADA provided a three-prong definition of disability, the first prong of which referred to both physical and mental impairments that substantially limit one or more major life activities of an individual.¹⁴ Regulations implementing the original ADA defined “physical or mental impairment” to include any physiological disorder as well as any mental or psychological disorder, including mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.¹⁵ Although the ADA regulations defined the major life activities that must be substantially limited as “functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working,”¹⁶ the interpretation of the phrase “substantially limit” was left to the courts. Before the enactment of the ADAAA, reviewing courts found that a number of individuals with physical and mental impairments,

10. *See id.* at Section III(A)-(E).

11. Americans with Disabilities Act (ADA), Pub. L. No. 101-336, 104 Stat. 327 (1990) [hereinafter ADA].

12. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3533 (2008) [hereinafter ADAAA].

13. ADA, *supra* note 11.

14. *Id.* § 3(2)(A)-(C) (pre-ADAAA definition of disability).

15. 29 C.F.R. § 1630.2(h)(1)-(2) (2009).

16. *See id.* § 1630.2(i).

including depressive and anxiety disorders, were not protected individuals with disabilities in part because their medications, psychotherapy, and other treatments constituted mitigating measures.¹⁷

In order to reinstate a broad scope of protection for individuals with disabilities, President George W. Bush signed the ADAAA into law on September 25, 2008.¹⁸ The ADAAA retains the ADA's basic three-prong definition of disability, including a physical or mental impairment that substantially limits one or more major life activities;¹⁹ however, the ADAAA clarifies the interpretation of the definition of disability in several important ways. For example, the ADAAA clarifies that an impairment that is episodic, such as bipolar disorder, remains a disability so long as it substantially limits a major life activity when active.²⁰ It also clarifies that the determination of whether an impairment substantially limits a major life activity should be made without regard to the ameliorative effects of mitigating measures, including psychotropic medications, learned behavioral modifications, and adaptive neurological modifications.²¹ Finally, the ADAAA contains an expanded list of major life activities that now includes the operation of an individual's neurological and brain functions.²²

On September 23, 2009, the Equal Employment Opportunity Commission ("EEOC") issued a proposed rule that would implement the ADAAA in the context of cases involving allegations of employment-based disability discrimination.²³ As adopted in final form on March 25, 2011,²⁴

17. See e.g., *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555, 565–66 (1999) (declaring that mitigating measures encompass not only artificial aids, such as medications and devices, but also measures undertaken, whether consciously or not, with the body's own systems, including subconscious mechanisms for compensating and coping with visual impairments); *Murphy v. United Parcel Service, Inc.*, 527 U.S. 516, 521 (1999) (noting that the determination of whether petitioner's impairment substantially limited one or more major life activities was properly made with reference to the mitigating factor of blood pressure medication); *Boerst v. Gen. Mills Operations*, No. 01-1483, 2002 WL 59637 at *408 (6th Cir. Jan. 15, 2002) ("[The plaintiff's] own testimony shows that he suffered no substantial limitation on his ability to work when Zolof's mitigating effects are taken into account."); *Orr v. Wal-Mart Stores, Inc.*, 297 F.3d 720, 724 (8th Cir. 2002) (dismissing the claims of a pharmacist with diabetes who controlled his condition with insulin injections and a controlled diet); *Nordwall v. Sears Roebuck & Co.*, No. 01-1691, 2002 WL 31027956 (7th Cir. Sept. 6, 2002) (dismissing the claims of an administrative assistant with diabetes who controlled her condition to some degree with daily blood sugar tests and daily injections of insulin); *Chenoweth v. Hillsborough Co.*, 250 F.3d 1328, 1330 (11th Cir. 2001), *cert. denied*, 534 U.S. 1131 (2002) (dismissing the claims of a nurse with focal onset epilepsy controlled by medication).

18. ADAAA, *supra* note 12, § 2(b).

19. *Id.* § 4(a) (amending 42 U.S.C. § 12102).

20. *Id.* § 4 (amending 42 U.S.C. § 12102).

21. *Id.*

22. *Id.*

23. Regulations To Implement the Equal Employment Provisions of the Americans With

the new EEOC regulations clarify that many mental illnesses, including major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, and schizophrenia, will meet the definition of disability due to their substantial limitation of the major life activity of brain function.²⁵ In summary, federal disability discrimination law includes both physical and mental impairments within the definition of disability. In addition, the ADAAA and its new implementing regulations confirm that individuals with mental disabilities, even if such mental disabilities are mitigated or are episodic in nature, are protected from disability discrimination in the same manner as are individuals with more traditional physical disabilities.²⁶

In addition to disability discrimination law, civil rights and human rights laws also provide equal protections for individuals with physical and mental disabilities. The Iowa Civil Rights Act of 1965, for example, provides equal protections for individuals with physical and mental disabilities in the employment, public accommodation, housing, education, credit, and other settings.²⁷ The Minnesota Human Rights Act also provides equal protections for individuals with physical and mental disabilities in the employment, housing, public accommodations, public services, and education contexts.²⁸ The State of Texas has enacted a number of civil rights provisions, including one that establishes a state policy of encouraging and enabling persons with disabilities to participate fully in the social and economic life of the state, to achieve maximum personal independence, to become gainfully employed, and to otherwise fully enjoy and use all public facilities available within the state.²⁹ The policy equally protects individuals with physical and mental disabilities.³⁰ The Illinois

Disabilities Act, as Amended, 74 Fed. Reg. 48431 (Sept. 23, 2009) [hereinafter Proposed ADAAA Regulations].

24. Regulations To Implement the Equal Employment Provisions of the Americans With Disabilities Act, as Amended, 76 Fed. Reg. 16978 (March 25, 2011 [hereinafter Final ADAAA Regulations].

25. *Id.* at 17001 (adding new 29 C.F.R. § 1630.2(j)(3)(i) (providing that, “It should easily be concluded that the following types of impairments will, at a minimum, substantially limit the major life activities indicated: . . . major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, and schizophrenia substantially limit brain function.”)).

26. *See id.* (adding new 29 C.F.R. § 1630.2(j)(1)(vi) (“The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures.”) and (adding new 29 C.F.R. § 1630.2(j)(1)(vii) (explaining, “An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.”)).

27. IOWA CODE §§ 216.1, 216.2(5) (2010).

28. MINN. STAT. §§ 363A.02, subd. 1, 363A.03, subd. 12 (2010).

29. TEX. HUM. RES. CODE § 121.001 (2010).

30. *Id.* § 121.002(4).

Human Rights Act (“IHRA”) similarly identifies freedom from unlawful discrimination as an important state public policy.³¹ To that end, the IHRA makes discrimination based on either physical or mental disability unlawful in a variety of settings, including employment, real estate, financial credit, and public accommodations.³²

In addition to civil rights and human rights laws, federal and state health information confidentiality laws also provide equal, if not more, confidentiality protections for individuals with mental illness. On August 21, 1996, President Clinton signed the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) into law.³³ Section 264 of HIPAA directed the federal Department of Health and Human Services (“HHS”) to adopt regulations protecting the privacy of individually identifiable health information if Congress failed to enact privacy legislation within three years of the date of HIPAA’s enactment.³⁴ When Congress failed to enact privacy legislation by its statutory deadline, HHS incurred the duty to adopt a privacy rule (“Privacy Rule”).³⁵ Under the Privacy Rule³⁶ as directed to be amended by President Obama through the Health Information Technology for Economic and Clinical Health (“HITECH”) Act,³⁷ both covered entities and business associates must maintain the confidentiality of protected health information (“PHI”) that they obtain, maintain, use, or disclose.³⁸ The Privacy Rule defines PHI as a subset of “individually identifiable health information”³⁹ which, in turn, is defined as a subset of “health information.”⁴⁰ “Health information” is defined to include any information relating to an individual’s past, present, or future physical or mental health condition.⁴¹ Regardless of whether a patient has a physical or

31. 775 ILL. COMP. STAT. §§ 5/1-101, 1-102(A) (2010).

32. *Id.* § 5/1-102(A).

33. The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996).

34. *Id.* § 264 (stating, “If legislation governing standards with respect to the privacy of individually identifiable health information . . . is not enacted by the date that is 36 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate final regulations containing such standards . . .”).

35. *Id.*

36. 45 C.F.R. § 164, subpart E.

37. The Health Information Technology for Economic and Clinical Health Act, *in* American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, §§ 13001-13424, 123 Stat. 115 (2009) [hereinafter, HITECH].

38. *Id.* § 13404(a); 45 C.F.R. § 164.500 (2010); Modifications to the HIPAA Privacy, Security, and Enforcement Rules Under the Health Information Technology for Economic and Clinical Health Act; Proposed Rule, 75 Fed. Reg. 40868, 40919 (July 14, 2010) [hereinafter the HIPAA Proposed Rule]. As of this writing, HHS has yet to issue a final rule modifying the HIPAA Privacy Rule in accordance with HITECH.

39. 45 C.F.R. § 160.103 (2010).

40. *Id.*

41. *Id.*

mental condition, then, the patient's PHI is protected under the Privacy Rule.

Interestingly, the Privacy Rule also provides heightened confidentiality protections for individuals with respect to their psychotherapy notes. The Privacy Rule defines "psychotherapy notes" as notes recorded by a mental health professional who is documenting or analyzing the contents of a conversation during an individual, group, joint, or family counseling session if such notes are separated from the rest of the medical records.⁴² Covered entities and business associates that maintain psychotherapy notes are permitted to use and disclose psychotherapy notes only in very limited situations.⁴³ On the other hand, covered entities and business associates are permitted to use non-psychotherapy note PHI in a broader range of situations, including in a variety of treatment, payment, healthcare operations, and public policy situations.⁴⁴ The Privacy Rule is not the only legal authority that provides equal (or greater) confidentiality protections to individuals with mental illnesses. A variety of other federal and state authorities provide special, or heightened, protections to the medical records of individuals who have mental illnesses, including records containing alcohol and drug abuse treatment information⁴⁵ as well as more general mental health information.⁴⁶

In addition to health information confidentiality law, the healthcare reform bill also contains several anti-discrimination provisions that apply equally to individuals with physical and mental illness. Section 1201 of the Patient Protection and Affordable Care Act as reconciled by the Health Care and Education Reconciliation Act (collectively, "ACA"), for example, clarifies that a group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility or continued eligibility based on certain health-related status factors, including both physical and mental illness.⁴⁷ Likewise, section 1302 of ACA requires qualified health plans to provide an essential health benefits package that includes not only traditional medical and surgical services, such as ambulatory patient services, emergency services, hospital services, maternity and newborn care, prescription drugs, rehabilitation services, laboratory services, preventive and wellness services, chronic

42. *Id.* § 164.501.

43. *Id.* § 164.508(a)(2).

44. *See, e.g., id.* §§ 164.506, 164.512.

45. *See, e.g.,* 42 C.F.R. § 2 (2010).

46. *See, e.g.,* IOWA CODE §§ 228.1, 228.2(1) (2010).

47. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) [hereinafter PPACA], as amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152 (2010) [hereinafter HCERA] [as consolidated, ACA] § 1201.

disease management, and pediatric services,⁴⁸ but also mental health and substance use disorder services, including behavioral health treatments.⁴⁹

Child and adult health and welfare laws that prohibit (and require the reporting of) abuse and neglect of children and vulnerable adults also are designed to prevent both physical and mental injuries and illnesses. Texas law, for example, requires a person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect to report the suspected abuse or neglect to a state authority.⁵⁰ Texas law defines 'abuse' as both physical injury that results in substantial harm to a child⁵¹ as well as mental and emotional injury to a child,⁵² and defines "neglect" in terms of both physical and mental neglect.⁵³ Similarly, Minnesota declares in its statutes a state policy of protecting adults who, "because of physical or mental disability," are particularly vulnerable to maltreatment.⁵⁴ To that end, the Minnesota Department of Human Services assists in providing safe environments for vulnerable adults, requires the reporting of suspected maltreatment of vulnerable adults, mandates the investigation of such reports, and provides protective and counseling services in appropriate cases.⁵⁵

II. DEFINITIONS OF HEALTH

I also wanted to examine the definitions of "health" provided by international, national, state, professional, and other authorities for use in a range of clinical, legal, and social contexts to see whether these authorities subordinate mental health to physical health or otherwise identify physical wellness as a greater contributor to overall health. I started with the World Health Organization ("WHO"), which is the directing and coordinating authority for health within the United Nations ("UN").⁵⁶ As part of its authority within the UN, the WHO is responsible for providing leadership on global health matters, shaping the public health research agenda, setting public health norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends.⁵⁷ Since 1948, the WHO has defined "health" as "a state of complete physical, mental and social well-being and not merely the

48. *Id.* § 1301(a)(1)(B); (b)(1)(A)-(D), (F)-(J).

49. *Id.* § 1302(b)(1)(E).

50. TEX. FAM. CODE §§ 261.101(a), 261.103 (2010).

51. *Id.* § 261.001(1)(c).

52. *Id.* § 261.001(1)(a).

53. *Id.* § 261.001(4)(a).

54. MINN. STAT. § 626.557, subd. 1 (2010).

55. *Id.*

56. World Health Organization, About WHO (2011), <http://www.who.int/about/en/>.

57. *Id.*

absence of disease or infirmity.”⁵⁸ The WHO definition thus fails to subordinate mental health to physical health and identifies both physical health and mental health as equal contributors to overall health.

HHS is the United States government’s principal agency for protecting the health of all Americans and providing essential human services.⁵⁹ HHS operates more than 300 programs that are, according to HHS, designed to provide for the “equitable treatment of beneficiaries nationwide.”⁶⁰ On its new HealthCare.gov Web site, HHS explains to all Americans: “[y]our mental health is just as important to your quality of life as your physical health. For too long, mental health has taken a back seat to physical health in our health insurance system. Mental health parity laws, including rules issued by the Obama administration earlier this year, have taken important steps forward to stop the insurance company practice of arbitrarily limiting care for mental health or substance use disorders.”⁶¹ Nowhere in any of its regulations does HHS define the word “health.” However, HHS defines “health care” in a number of its regulations to include care relating to the “physician or mental condition” of an individual.⁶² HHS also defines “patient” as “any individual who is receiving health care items or services, including any item or service provided to meet his or her physical, mental or emotional needs or well-being”⁶³ HHS further defines “health information” as “any information . . . relating to the past, present, or future physical or mental condition of an individual”⁶⁴

HHS heavily regulates healthcare providers and suppliers that participate in and receive reimbursement from federal and state healthcare programs, including Medicare and Medicaid. HHS’ regulations are designed to equally protect patients’ physical and mental health. For example, Medicare-participating hospitals are prohibited from physically and mentally abusing their inpatients and outpatients.⁶⁵ Medicare-participating nursing homes also are prohibited from physically and mentally abusing their residents.⁶⁶ HHS requires Medicare-participating nursing homes to develop care plans that will attain for nursing home residents their “highest

58. World Health Organization, Definition of Health (2011), <https://apps.who.int/about/who/en/definition.html>.

59. U.S. Dep’t Health & Human Servs., About HHS (2010), <http://www.hhs.gov/about/>.

60. *Id.*

61. Pamela S. Hyde, *The Affordable Care Act & Mental Health: An Update*, HEALTHCARE BLOG (Aug. 19, 2010), <http://www.healthcare.gov/blog/2010/08/mentalhealthupdate.html>.

62. *See, e.g.*, 45 C.F.R. § 160.103 (2010).

63. *See, e.g.*, 42 C.F.R. § 1001.2 (2010).

64. *See, e.g.*, 45 C.F.R. § 160.103 (2010).

65. 42 C.F.R. § 482.13(e) (2010).

66. *Id.* § 483.13(b).

practicable physical, mental, and psycho-social well-being.”⁶⁷ HHS also requires state Medicaid plans to provide early and periodic screening and diagnosis of eligible Medicaid recipients under age twenty-one to ascertain both “physical and mental defects” and to provide treatments for such defects.⁶⁸ In summary, HHS does not subordinate mental health to physical health in any of its programs, services, or requirements, and appears to have as its goal the promotion of both physical and mental health. Indeed, the Surgeon General of the United States Public Health Service, a department within HHS, explains that “one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between “mental” and “physical” health.”⁶⁹

In addition to international organizations and national agencies such as WHO and HHS, federal and state courts and legislatures also interpret health to include both physical and mental components. *Words and Phrases*, a multi-volume treatise containing thousands of judicial definitions of words and phrases that have taken on special meaning in the law, contains an entry for the word “health” that identifies thirteen relevant federal and state court opinions.⁷⁰ Almost all of these court opinions define “health” with express reference to both physical and mental health, and not one of these judicial opinions expressly limits health to physical health. In *U.S. v. Vuitch*, for example, the United States Supreme Court interprets the definition of “health” with respect to the District of Columbia’s abortion statute to include both physical and mental health.⁷¹ In *State v. Payne*, the Supreme Court of Connecticut interprets the word “health” for purposes of a Connecticut criminal child protection statute, and includes in such interpretation both physical and mental health.⁷² In *Gross v. State*, the Court of Appeals of Indiana clarifies that the word “health” for purposes of an Indiana criminal dependency neglect statute is not limited to physical health, but also includes an individual’s psychological, mental, and

67. *Id.* § 483.20(k)(1)(i).

68. *Id.* § 441.50.

69. U.S. DEP’T HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 418 (1999) [hereinafter SURGEON GENERAL REPORT].

70. *Health*, in WORDS & PHRASES 269, 269-70 (West 2005).

71. *U.S. v. Vuitch*, 402 U.S. 62, 72 (1971).

72. *State v. Payne*, 695 A.2d 525, 528 (Conn. 1997) (stating,

We agree that, because the phrase “life or limb is endangered” indicates the intent of the legislature to protect children from conduct creating a risk of physical injury, and because the phrase “morals likely to be impaired” expresses the legislature’s intent to prohibit conduct threatening the morality of children, the phrase “health is likely to be injured” must include the risk of injury to the mental health of a child in order to avoid redundancy within the first part of the statute.).

emotional health.⁷³ In *Venable v. Gulf Taxi Line*, a final example involving a motor car personal injury case dating back to the early 1900s, the Supreme Court of Appeals of West Virginia explained that the word “health” means “the state of being hale, sound, or whole in body, mind or soul.”⁷⁴

Medical and lay dictionaries and classification manuals also define “health” with reference to both physical and mental well-being. *Dorland’s Medical Dictionary* defines “health” as “[a]n optimal state of physical, mental, and social well-being; the popular idea that it is merely an absence of disease and infirmity is not complete.”⁷⁵ *Black’s Law Dictionary* defines “health” as “[t]he state of being sound or whole in body, mind, or soul.”⁷⁶ *The American Heritage Dictionary of the English Language* defines “health” as “[s]oundness, especially of body or mind . . .”⁷⁷ The current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (“DSM”) does not contain a definition of “health.”⁷⁸ However, the DSM does in its discussion of the term “mental disorder” state that the term implies a distinction between mental disorders and physical disorders “that is a reductionistic anachronism of mind/body dualism.”⁷⁹ According to the DSM, “[a] compelling literature documents that there is much ‘physical’ in ‘mental’ disorders and much ‘mental’ in ‘physical’ disorders.”⁸⁰

III. THE MIND-BODY PROBLEM

Notwithstanding the fact that health-related doctrine outside the context of mental health parity law prohibits discrimination against individuals with mental illness and the fact that international, national, state, professional, and other definitions of “health” fail to subordinate mental health to physical health or otherwise identify physical wellness as a greater contributor to overall health, current federal mental health parity law continues to allow many public health care program beneficiaries and

73. *Gross v. State*, 817 N.E.2d 306, 308 (Ind. App. 2004) (stating, “Under the neglect statute, ‘health’ is not limited to one’s physical state, but includes an individual’s psychological, mental and emotional status.”).

74. *Venable v. Gulf Taxi Line*, 141 S.E. 622, 624 (W.Va. 1928) (stating, “As counsel very well argue by their reference to the definitions given in the books, health means the ‘state of being hale, sound or whole in body, mind or soul, well being.’”).

75. DORLAND’S ILLUSTRATED MEDICAL DICTIONARY (2007), available at <http://www.credoreference.com/entry/ehsdorland/health>.

76. BLACK’S LAW DICTIONARY 737 (8th ed. 2004).

77. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 808 (Houghton Mifflin 2006).

78. See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (2000).

79. *Id.* at xxx.

80. *Id.*

private health plan members to be subject to inferior mental health insurance benefits. I suggest that these remaining legal distinctions between physical and mental illness may emanate from the centuries-old mind-body problem, which continues to animate health law, philosophy of the mind, and other legal and philosophical doctrine.⁸¹

The central feature of the mind-body problem is the nature of the relationship between the mind and the body, including the relationship that exists between minds (or mental processes) and body states (or physical processes).⁸² The two major schools of thought that attempt to resolve the mind-body problem include dualism and monism.⁸³ Substance dualists argue that the mind is an independently existing substance,⁸⁴ whereas property dualists maintain that the mind is not a distinct substance but that the mind is a group of independent properties that emerge from and cannot be reduced to the brain.⁸⁵ Monists, on the other hand, believe that mind and body are not ontologically entities.⁸⁶ Most modern philosophers of the mind adopt a reductive or non-reductive physicalist position, maintaining in their different ways that the mind is not something separate from the body.⁸⁷ Reductive physicalists assert that all mental states and properties

81. See, e.g., Kirk Ludwig, *The Mind-Body Problem: An Overview*, in THE BLACKWELL GUIDE TO PHILOSOPHY OF MIND 1-46 (Stephen P. Stich & Ted A. Warfield eds., 2007) (explaining the traditional mind-body problem, possible solutions, and obstacles to solutions); SUSAN SCHNEIDER, *THE MIND-BODY PROBLEM: RETHINKING THE SOLUTION SPACE* (forthcoming Oxford University Press 2011) (examining leading solutions to the mind-body problem); John R. Searle, *The Future of Philosophy*, 354 PHIL. TRANSACTIONS: BIOLOGICAL SCI. 2069, 2075 (1999) (explaining that the mind-body problem is one part of a much broader set of issues known collectively as the philosophy of mind).

82. See, e.g., Searle, *supra* note 81, at 2073 (asking, "What exactly are the relations between consciousness and the brain?").

83. See, e.g., Cecil H. Miller, *The Basic Question: Monism or Dualism?* 14 PHIL. SCI. 1, 7-12 (1947) (describing the competing schools of monism and dualism; concluding, in 1947, "That the substance of monism is sufficient, however, has by no means been proven. For dualism will still be tenable until the last bit of the unknown has been made a part of the known. And at least until then articulate human beings, we may be certain, will continue to give it devout and enthusiastic support.").

84. See, e.g., Ludwig, *supra* note 81, at 13 (examining substance dualism); William C. Lycan, *Giving Dualism its Due*, 87 AUSTRALASIAN J. PHIL. 551, 551-63 (2009) (arguing that no convincing case has been made against substance dualism).

85. See, e.g., Howard Robinson, *Dualism*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2009), <http://plato.stanford.edu/entries/dualism/> (examining property dualism and explaining that, "In the case of mind, property dualism is defended by those who argue that the qualitative nature of consciousness is not merely another way of categorizing states of the brain or of behaviour, but a genuinely emergent phenomenon.").

86. See, e.g., PATRICIA SMITH CHURCHLAND, *TOWARD A UNIFIED SCIENCE OF THE MIND-BRAIN* 3 (MIT Press 1986) (developing a monist, or unified, theory of the mind-brain); Miller, *supra* note 83, at 7 (stating, "Monism, postulating a single, universal and homogeneous substance, lays itself open to charges of oversimplification and reduction.").

87. See, e.g., Ludwig, *supra* note 81, at 9 (characterizing physicalism); Daniel Stoljar, *Physicalism*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2009),

will eventually be explained by scientific accounts of physiological processes and states.⁸⁸ Non-reductive physicalists argue that although the brain is all there is to the mind, the predicates and vocabulary used in mental descriptions and explanations are indispensable, and cannot be reduced to the language and lower-level explanations of physical science.⁸⁹ Other modern philosophers, however, adopt a non-physicalist position that challenges the notion that the mind is a purely physical construct.⁹⁰

Countless legal subjects are influenced by the mind-body problem. Clear examples include the nature of the concepts of personhood and responsibility for purposes of criminal law,⁹¹ the nature of the concepts of personhood, consciousness, and death for purposes of withholding and withdrawing life-sustaining treatment as well as organ donation law,⁹² and

available at <http://plato.stanford.edu/entries/physicalism/> (examining reductive and non-reductive physicalism).

88. *See, e.g.,* Stoljar, *supra* note 87 (explaining, “Applied to the philosophy of mind, th[e] notion [of reductive physicalism] might be thought of entailing the idea that every mental concept or predicate is analyzed in terms of a physical concept or predicate.”).

89. *See, e.g.,* Robert Van Gulick, *Consciousness*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2009), *available at* <http://plato.stanford.edu/entries/consciousness/> (explaining, “Non-reductive physicalism . . . denies that the theoretical and conceptual resources appropriate and adequate for dealing with facts at the level of the underlying substrate or realization level must be adequate as well for dealing with those at the realized level”). *But see* Jaegwon Kim, *The Myth of Non-Reductive Materialism*, PROCEEDINGS & ADDRESSES AM. PHIL. ASSOC., Nov. 1989, at 31, 32 (claiming that a physicalist only has two options; that is, eliminativism and reductionism; arguing that non-reductive materialism is a myth).

90. *See, e.g.,* Stoljar, *supra* note 87 (presenting three cases against physicalism, including qualia and consciousness, meaning and intentionality, and methodological issues).

91. *See, e.g.,* Joshua Greene and Jonathan Cohen, *For the Law, Neuroscience Changes Nothing and Everything*, in NEUROETHICS: AN INTRODUCTION WITH READINGS 232-258 (Martha J. Farah ed., 2010) (examining whether our emerging understanding of the mind as brain really has any deep implications for the law); Stephen J. Morse, *Brain Overclaim Syndrome and Criminal Responsibility: A Diagnostic Note*, in NEUROETHICS: AN INTRODUCTION WITH READINGS 268-280 (Martha J. Farah ed., 2010) (providing a contextual foundation for how to think about the relation of neuroscience to criminal responsibility); Stephen Morse, *Moral and Legal Responsibility and the New Neuroscience*, in NEUROETHICS: DEFINING THE ISSUES IN THEORY, PRACTICE, AND POLICY 33-50 (Judy Illes ed., Oxford Univ. Press 2006) (describing the dominant conception of personhood and responsibility in Western law and morality and contending that neuroscience is largely irrelevant if the concept of responsibility is properly understood and evaluated); Stephen Sedley, *Responsibility and the Law*, in THE NEW BRAIN SCIENCES: PERILS AND PROSPECTS 123-130 (Dai Rees & Steven Rose eds., 2004) (viewing the law on human responsibility for acts which harm others as a set of historic and moral compromises).

92. *See, e.g.,* Abdallah S. Daar, *The Body, the Soul, and Organ Donation Beliefs of the Major World Religions*, 14 NEFROLOGIA 78, 78-81 (1994) (examining religious and philosophical approaches to living organ donation, cadaver organ donation, and the establishment of death using brain-death criteria); Renée C. Fox & David P. Willis, *Personhood, Medicine, and American Science*, 61 MILBANK MEM. FUND QUARTERLY, HEALTH & SOC'Y 127, 129 (1983) (explaining that discussions about personhood in the context of bioethics frequently focus on the withholding and withdrawal of life-sustaining

the nature of the concepts of physical health and mental health for purposes of health insurance law and mental health parity law.⁹³ If an expert who testifies in a health insurance coverage dispute brings to her testimony a reductive physicalist perspective and asserts that all mental states and properties eventually will be explained by scientific accounts of physiological processes, then the outcome may be the classification of a traditional mental illness as a physical illness for purposes of interpreting the health insurance policy. On the other hand, a substance dualist may object to a legal merger of physical and mental illness for purposes of health insurance law as well as other areas of civil, criminal, and administrative doctrine. I suggest that the mind-body problem, which stubbornly resists solution,⁹⁴ also may be playing a role in the persistence of mental health benefit disparities.

IV. THE ROLE OF STIGMA

If the relevant clinical, economic, and social literatures do not support mental health benefit disparities,⁹⁵ why do they remain? If studies show that mental health parity implementation has not increased and may actually decrease total health care costs,⁹⁶ why is mental health parity not mandatory across all payor settings? If studies show that untreated mental illness is associated with decreased rates of work productivity and increased rates of disability, homelessness, welfare, and criminal activity,⁹⁷ why do our federal and state legislatures not prioritize mental health parity and justify it as a benefit to society? If courts are unable to meaningfully distinguish between physical and mental illness in health insurance coverage disputes,⁹⁸ why do judges insist on perpetuating artificial distinctions based on the area of specialization of the treating health care provider, the nature and type of treatment, the origin of the illness, and the symptoms of the illness? If other areas of health-related legal doctrine do not provide inferior legal protections or benefits for individuals with mental illness, why does health insurance law continue to do so? If international, national, state, and

treatment).

93. See, e.g., SURGEON GENERAL REPORT, *supra* note 69, at 5-6 (containing a separate section entitled, "Mind and Body Are Inseparable" and referencing within that section theories of the mind and its relation to the body).

94. See, e.g., Ludwig, *supra* note 81, at 29-30 (explaining the persistence of the mind-body problem); Colin McGinn, *Can We Solve the Mind-Body Problem?* 98 MIND 349, 349-366 (1989) (stating, "We have been trying for a long time to solve the mind-body problem. It has stubbornly resisted our best efforts. The mystery persists. I think the time has come to admit candidly that we cannot resolve the mystery.").

95. See Tovino, *supra* note 1, at Sections I(B)-(E).

96. See *id.* at Section I(B).

97. See *id.* at Section I(C).

98. See *id.* at Section I(E).

professional definitions of “health” used throughout the clinical, legal, and social literatures fail to subordinate mental health to physical health, why does health insurance law continue to do so?

I believe the answer is stigma.⁹⁹ The stigma associated with mental illness has served as a formidable obstacle to mental health parity even when all other obstacles have been removed.¹⁰⁰ Identifying the reasons for persistent mental health disparities is important for framing an argument against them. I could frame my mental health parity proposals as economic efficiency measures aimed to achieve cost savings in public and private payor settings. I also could frame mental health parity as a social measure that is necessary to resolve problems associated with unemployment, disability, homelessness, welfare, and criminal activity. The data I presented in my earlier work¹⁰¹ would support the characterization of my mental health parity proposals in both of these ways. I prefer instead to frame mental health parity as both a clinically-oriented and anti-discrimination measure that is intended to reduce the suffering of, improve the daily functioning of, and remove the stigma associated with individuals who have mental illness.

Elsewhere, I traced and closely examined the roots of stigma associated with mental illness.¹⁰² Historically, individuals with mental illness were regarded with contempt, fear, and cruelty, perhaps due to the belief that mental illness stemmed from poor parenting, demonic possession, or deficient character.¹⁰³ Mental illness remains poorly understood today.¹⁰⁴ Mental Health America, the leading U.S. nonprofit organization devoted to improving the lives of individuals with mental illness, estimates that 71 percent of Americans continue to believe that mental illness is caused by mental weakness, 65 percent believe that mental illness is the product of poor parenting, and 35 percent believe that mental illness is a form of retribution for sinful or immoral behavior.¹⁰⁵ According to the Surgeon

99. SURGEON GENERAL REPORT, *supra* note 69, at 3 (stating, “The most formidable obstacle to mental health parity is stigma.”).

100. *See id.* (arguing that, “Stigmatization of mental illness is an excuse for inaction and discrimination that is inexcusably outmoded”); UNIV. TEXAS MENTAL HEALTH POLICY ANALYSIS COLLABORATIVE, THE CONSEQUENCES OF UNTREATED MENTAL ILLNESS IN HOUSTON 18 (Sept. 2009) [hereinafter, UNTREATED MENTAL ILLNESS] (stating, “Although there has been recent improvement, today mental illness remains one of the most stigmatized of all medical disorders.”).

101. *See* Tovino, *supra* note 1, at Part I(B)-(E).

102. *See, e.g.,* Stacey A. Tovino, *Neuroscience and Health Law: An Integrative Approach?* 42 AKRON L. REV. 469, 475 (2009).

103. *Id.*

104. *Id.*

105. *Id.* *See generally* Mental Health America, *Welcome* (2010), <http://www.nmha.org/> (characterizing itself as the country’s leading nonprofit organization dedicated to helping all people live mentally healthier lives.).

General, the stigma associated with mental illness manifests itself through bias, distrust, stereotyping, fear, embarrassment, anger, and avoidance of individuals with mental illness.¹⁰⁶ The stigma associated with mental illness also contributes to people avoiding living with, socializing with, working with, renting to, and employing mentally ill individuals.¹⁰⁷ The stigma associated with mental illness also deters patients from seeking, and the public and third party payors from wanting to pay for, mental health care.¹⁰⁸ Perhaps most concerning, the stigma associated with mental illness deprives mentally ill individuals of their dignity and interferes with their ability to fully participate in society.¹⁰⁹ In an attempt to reduce the suffering and improve the daily functioning of individuals with mental illness and to remove the stigma associated with mental illness,¹¹⁰ I thus continue to propose the extension of mental health parity law and mandatory mental health and substance use disorder benefits to all public health care program beneficiaries and private health plan members.

106. SURGEON GENERAL REPORT, *supra* note 69, at 6.

107. *See id.*; UNTREATED MENTAL ILLNESS, *supra* note 100, at 18 (stating, “People are no more willing to have social connections to people with mental illness today than in the past.”).

108. SURGEON GENERAL REPORT, *supra* note 131, at 6. *See also id.* at 8 (stating, “Another manifestation of stigma is reflected in the public’s reluctance to pay for mental health services.”); *id.* at 454 (stating, “[Stigma] gives insurers – in the public sector as well as the private – tacit permission to restrict coverage for mental health services in ways that would not be tolerated for other illnesses.”).

109. *Id.* at 6.

110. *See also id.* at 454 (stating, “For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated.”).