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A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits

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A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits

Stacey A. Tovino[†]

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I. INTRODUCTION

This Article analyzes the initial efforts of the Federal Department of Health and Human Services (HHS) to implement the essential mental health and substance use disorder services benefit required by section 1302(b)(1)(E) of the Affordable Care Act (ACA)¹ and proposes the adoption of a comprehensive and specific essential mental health and substance use disorder benefit set. At a minimum, the benefit set should cover medically necessary and evidence-based inpatient and outpatient mental healthcare services, inpatient substance abuse detoxification services, inpatient and outpatient substance abuse rehabilitation services, emergency mental healthcare services, prescription drugs for mental health conditions, participation in psychiatric disease management programs, and community-based mental healthcare services.

This Article builds on three previous articles that have proposed reforms of federal and state mental health parity laws and mandatory mental health and substance use disorder benefit laws. The first article in this series challenged the less comprehensive public and private health insurance benefits that historically have been available to individuals who have illnesses traditionally classified as mental and proposed changes to federal statutes and regulations governing Medicare, Medicaid, self-funded non-federal governmental health plans, small group health plans, large group health plans, and grandfathered health plans.² The first article proposed extending 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.³ The second article in the series justified and proposed amendments to divergent state mental health parity laws and offered a uniform mental health parity law for consideration by state legislatures.⁴ The third article provided additional support for my earlier 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.⁵ The third article grounded such support in health-related doctrine outside the context of mental health insurance law (including disability discrimination law, civil rights and

¹ Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (to be codified primarily in scattered sections of 42 U.S.C.). Section 1302(b)(1)(E) of the Affordable Care Act provides: “The Secretary [of HHS] shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: . . . (E) Mental health and substance use disorder services, including behavioral health treatment.”

² See Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1 (2012).

³ See *id.*

⁴ See Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL’Y 455 (2011).

⁵ See Stacey A. Tovino, *Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits*, 21 ANNALS HEALTH L. 147 (2012).

human rights law, health information confidentiality law, and child and adult health and welfare law) as well as international, national, state, and professional definitions of “health.”⁶ The third article also contextualized remaining mental health benefit disparities in terms of the centuries-old mind-body problem and the stigma that continues to be associated with mental illness.⁷

At the time these three articles were written, HHS has not yet attempted to implement the essential health benefits provision in section 1302 of ACA (the “EHB Provision”), which requires exchange-offered qualified health plans, non-exchange-offered individual health plans, non-exchange-offered small group health plans, Medicaid benchmark and benchmark-equivalent plans, and state basic health plans to cover at least ten general categories of health services.⁸ The ten required categories of services include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care) (collectively, the “EHB Package”).⁹

During the last year, HHS has taken initial steps to implement the EHB Provision. As discussed in more detail in Parts III.D and III.E, *infra*, HHS requested guidance from the Institute of Medicine (IOM) on the criteria and methods that should be used to determine and update the EHB Package.¹⁰ In response, the IOM formed the Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans (“Committee”).¹¹ The Committee responded by providing opportunities for the public to comment on the EHB Package through two different venues,¹² including through a Web-distributed questionnaire relating to the EHB Package¹³ and through public workshops held on January 13-14, 2011, in Washington, D.C., and on March 2, 2011, in Costa Mesa, California.¹⁴ The speakers invited to these workshops included experts from federal and state government, employers, insurers, healthcare providers, consumers, and healthcare researchers.¹⁵ On August 29, 2011, the Committee released a report entitled, *Perspectives on Essential Health Benefits: Workshop Report* (“*Workshop Report*”), which summarized the speaker presentations from the D.C. and Costa Mesa workshops but did not contain the Committee’s own recommendations regarding the EHB Package.¹⁶

On October 7, 2011, the Committee released its own consensus report entitled, *Essential Health Benefits: Balancing Coverage and Costs* (“*Consensus Report*”).¹⁷

⁶ *Id.*

⁷ *Id.*

⁸ ACA, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119 (2010).

⁹ *See id.* § 1302(b)(1)(A)-(J).

¹⁰ INST. OF MED., PERSPECTIVES ON ESSENTIAL HEALTH BENEFITS: WORKSHOP REPORT 1 (2011) [hereinafter WORKSHOP REPORT].

¹¹ *Id.* at 1-2.

¹² *Id.*

¹³ *Id.* at 2, 161 app. B (“Web-Based Questions for Public Input on Determination of Essential Health Benefits.”).

¹⁴ *Id.* at 2 box S-1.

¹⁵ *Id.*

¹⁶ *Id.* at 15.

¹⁷ INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST (2011) [hereinafter CONSENSUS REPORT].

In the *Consensus Report*, the Committee recommended that the Secretary of HHS (“Secretary”) define the EHB Package to reflect the scope and design of health benefits offered by small employers.¹⁸ The Committee also identified criteria for the content of the aggregate EHB Package and specific components of the EHB Package,¹⁹ as well as four policy foundations that should guide the Secretary in determining the EHB Package, including economics, ethics, population-based health, and evidence-based practice.²⁰ Finally, the Committee made five specific sets of recommendations. The Committee first recommended that the Secretary establish a specific EHB Package benchmarked to a typical small employer plan, modified as necessary to reflect the ten ACA-required benefit categories, and guided by a national average premium target.²¹ The Committee’s second through fifth recommendations related to establishing a framework for obtaining and analyzing data necessary for monitoring and implementing the EHB Package, promoting state innovation, updating the EHB Package, and creating a National Benefits Advisory Council (NBAC).²²

Following the release of the *Consensus Report*, HHS held an additional series of “listening sessions” with consumers, providers, employers, plans, state representatives, and other stakeholders in different cities across the United States.²³ On December 16, 2011, HHS released its *Essential Health Benefits Bulletin* (“*EHB Bulletin*”).²⁴ The *EHB Bulletin* provides information and solicits comments on a regulatory approach that HHS plans to propose to define the EHB Package.²⁵ In the *EHB Bulletin*, HHS explains its intent not to propose one comprehensive, specific benefit package for all health plans in the nation to follow.²⁶ Instead, HHS intends to leave the states broad discretion in defining the EHB Package by allowing each state to select a benchmark plan in that state.²⁷ The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a typical employer plan in that state.²⁸ HHS intends to allow health plans to make adjustments to the benchmarked benefits (including adjustments to the specific services covered and to any quantitative limits provided) and is considering allowing health plans to substitute services both within and across the ten ACA-required benefit categories.²⁹

This Article analyzes the initial steps taken by HHS to implement the EHB Provision,³⁰ with a focus on the essential mental health and substance use disorder

¹⁸ *Id.* at 2.

¹⁹ *Id.* at 3-12.

²⁰ *Id.* at 4 fig.S-1.

²¹ *Id.* at 90.

²² *Id.* at 8-12.

²³ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T HEALTH & HUMAN SERVS., ESSENTIAL HEALTH BENEFITS BULLETIN 3 (2011) [hereinafter EHB BULLETIN], available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

²⁴ *Id.*

²⁵ *Id.* at 1.

²⁶ *Id.* at 8-12; see also Rebecca Farley, *Essential Health Benefits: What Does the New HHS Guidance Mean for Behavioral Health*, MENTAL HEALTHCARE REF. (Dec. 22, 2011), <http://mentalhealthcarereform.org/essential-health-benefits-what-does-the-new-hhs-guidance-mean-for-behavioral-health/>.

²⁷ EHB BULLETIN, *supra* note 23, at 8.

²⁸ *Id.*

²⁹ *Id.* at 12.

³⁰ ACA, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119, 163 (2010), codified at 42 U.S.C.A § 18022 (West 2012).

sub-provision codified at section 1302(b)(1)(E) of ACA (the “Mental Health Benefit Sub-Provision”).³¹ Thus far, HHS understandably has focused on the ten ACA-required benefit categories as a whole and not just the Mental Health Benefit Sub-Provision.³² In its *Workshop Report*, the Committee explained that “time constraints prohibited the [C]ommittee from hearing testimony related to each of the[] [ten ACA-required] categories in detail.”³³ The scant attention received by mental health and substance use disorder benefits from HHS likely is a result of the time constraints faced by the Committee. Notwithstanding, the result is a tentative HHS plan that is timid with respect to the comprehensiveness and specificity of all benefits, including mental and substance use disorder benefits. This Article urges HHS to consider the possibility of long-term total healthcare cost returns on initial comprehensive mental health treatment investments. This Article also seeks to remedy the informational and research limitations in HHS’s initial implementation of the EHB Provision.

This Article proceeds as follows: Part II examines the historically inferior public and private health insurance benefits available to individuals with illnesses traditionally classified as mental. Part III reviews the development, application, and limitations of relevant federal mental health insurance laws, recommendations, and proposals, including the Mental Health Parity Act of 1996, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Affordable Care Act of 2010, the *Workshop Report* issued on August 29, 2011, the *Consensus Report* issued on October 7, 2011, and the *EHB Bulletin* issued on December 16, 2011. Part IV examines the current health plan cost literature that supports mental health parity and comprehensive mental health and substance use disorder benefits. Part IV also justifies and proposes the adoption of a comprehensive and specific essential mental health and substance use disorder services benefit.

II. HISTORICALLY INFERIOR INSURANCE BENEFITS FOR INDIVIDUALS WITH MENTAL ILLNESS³⁴

A. INFERIOR PUBLIC HEALTH PROGRAM BENEFITS

Public healthcare programs and private health insurers have long provided less comprehensive insurance benefits to individuals with mental illness in both the inpatient³⁵ and outpatient³⁶ settings.³⁷ The Medicare program, a public healthcare

³¹ *Id.* § 1302(b)(1)(E).

³² See *infra* notes 153, 228-32 and accompanying text.

³³ WORKSHOP REPORT, *supra* note 10, at 71.

³⁴ Part II of this Article is reprinted with updates and minor changes with permission from Tovino, *supra* note 2, at pt. 1.

³⁵ An inpatient may be defined as a patient who: (1) receives room, board, and professional services in a medical institution for a twenty-four-hour period or longer; or (2) is expected by the institution to receive room, board, and professional services in the institution for a twenty-four-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 twenty-four hours. See 42 C.F.R. § 440.2(a) (2010).

³⁶ 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 twenty-four-hour period regardless of the hour of admission, whether a bed is used, and whether the patient remains in the facility past midnight. See *id.*

program funded and administered by the U.S. government, provides health insurance for individuals who are sixty-five years of age or older, individuals under the age of sixty-five who have certain disabilities, and individuals with end-stage renal disease regardless of age.³⁸ Both Medicare Part A, which provides hospital insurance benefits,³⁹ and Medicare Part B, which provides physician and other supplementary medical insurance benefits,⁴⁰ provide less comprehensive insurance benefits for beneficiaries with mental illness.

Medicare Part A restricts beneficiaries to a lifetime maximum of 190 inpatient days in a free-standing psychiatric hospital but places no lifetime maximum on the number of days a beneficiary may stay as an inpatient in a non-psychiatric hospital.⁴¹ The federal government justifies the 190-day limitation as a cost-control measure.⁴² Some Medicare beneficiaries with severe chronic mental illnesses, including chronic schizophrenia and affective disorders, would easily exceed 190 inpatient days over their lifetime without the limitation.⁴³ With the limitation, affected beneficiaries are limited to: (1) Medicare-covered outpatient mental healthcare, which may be insufficiently intense to treat an acute illness episode and may result in suicide or other poor outcomes; (2) Medicare-covered inpatient care provided in a non-psychiatric setting by clinicians who may lack the education, training, and experience necessary to treat complex psychiatric conditions; or (3) non-covered inpatient care provided in a psychiatric setting for which the beneficiary must pay entirely out of pocket.⁴⁴ Some beneficiaries who consider unsatisfactory the options

³⁷ See, e.g., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEP'T HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 418 (1999) [hereinafter SURGEON GENERAL REPORT] ("Private health insurance is generally more restrictive in coverage of mental illness than in coverage for somatic illness."). *Id.* ("Federal public financing mechanisms, such as Medicare and Medicaid, also imposed limitations on coverage . . . of 'nervous and mental disease' . . ."); Colleen L. Barry, *The Political Evolution of Mental Health Parity*, 14 HARV. REV. PSYCHIATRY 185, 186 (2006) [hereinafter Barry, *Political Evolution*] ("Ever since the inception of third-party payment for mental health services, coverage has been substantially more limited than insurance for general medical care.").

³⁸ See 42 U.S.C. § 1395c (2006). See generally CTRS. MEDICARE & MEDICAID SERVS., DEP'T HEALTH & HUMAN SERVS., CMS PRODUCT NO. 11306, WHAT IS MEDICARE? (2011).

³⁹ See 42 U.S.C. §§ 1395c-1395i-5 (2006 & Supp. IV 2010) (establishing "[Medicare] Part A—Hospital Insurance Benefits for Aged and Disabled").

⁴⁰ See *id.* §§ 1395j-1395w-4 (establishing "[Medicare] Part B—Supplementary Medical Insurance Benefits for Aged and Disabled").

⁴¹ See 42 C.F.R. § 409.62 (2010); see also NAT'L POLICY FORUM, MEDICARE'S MENTAL HEALTH BENEFITS 1 (2007); CONG. BUDGET OFFICE, CBO STAFF MEMORANDUM: THE INPATIENT PSYCHIATRIC HOSPITAL BENEFIT UNDER MEDICARE 4-5 (1993) [hereinafter CBO MEMORANDUM].

⁴² See Judith R. Lave & Howard H. Goldman, *Medicare Financing for Mental Health Care*, 9 HEALTH AFF. 19, 21 (1990) ("This limit assures that Medicare will not pay for the long-term custodial support of the mentally ill."); NAT'L POLICY FORUM, *supra* note 41, at 10 (explaining that Medicare Part A's 190-day lifetime maximum on mental healthcare provided in a free-standing psychiatric hospital was intended to limit the federal government's mental healthcare costs).

⁴³ See, e.g., Letter from Michael J. Fitzpatrick, Exec. Dir., Nat'l Alliance on Mental Illness, to Rep. Paul Tonko (Sept. 20, 2010), available at http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=107512 (explaining that many non-elderly Medicare beneficiaries with disabilities have already exceeded the 190-day limit or are at imminent risk of doing so).

⁴⁴ CBO MEMORANDUM, *supra* note 41, at 13 (noting that once a Medicare beneficiary reaches the 190-day limitation, the beneficiary may turn for care to a general hospital (where the limit does not apply) or to outpatient care, or may forgo psychiatric care entirely); *id.* at 10 ("[T]he alternative provider might be less capable of providing the most appropriate care if psychiatric hospitals have specialized in treating certain kinds of patients—for example, those who need acute care for severe or complex conditions."); CAL. HEALTH ADVOCATES, SUMMARY OF MEDICARE BENEFITS AND COST

of outpatient mental healthcare or inpatient care in a non-psychiatric setting may forgo mental healthcare entirely if they are unable to pay 100 percent of the costs of inpatient care provided in a psychiatric setting.⁴⁵

In addition to the Medicare Part A limitation on inpatient care provided in a free-standing psychiatric hospital, Medicare Part B also provides less comprehensive outpatient mental health benefits than non-mental health benefits.⁴⁶ In particular, Medicare Part B currently imposes a forty percent beneficiary co-insurance⁴⁷ on most outpatient mental health services, including individual, family, and group psychotherapy services, instead of the twenty percent beneficiary co-insurance traditionally applied to non-mental health outpatient services.⁴⁸ Although Medicare will phase out the disparate co-insurances by the year 2014, Medicare beneficiaries who receive outpatient mental health services between the present and 2014 will be required to pay more out of pocket for outpatient mental health services compared to outpatient physical health services.⁴⁹

The Medicaid Program, a public healthcare program jointly funded by the federal and state governments and administered by the states, provides healthcare to certain low-income individuals and families who fit into an eligibility group recognized by federal and state law.⁵⁰ Like the Medicare Program, the Medicaid Program also has limited support for individuals who require mental healthcare in certain inpatient psychiatric settings. For example, Medicaid does not cover inpatient mental healthcare provided to individuals age twenty-two through sixty-four in an

SHARING FOR 2011 (2010), *available at* <http://www.cahealthadvocates.org/basics/benefits-summary.html> (explaining that Medicare beneficiaries pay out of pocket for 100% of the costs of inpatient services provided in a psychiatric setting after 190 days).

⁴⁵ CBO MEMORANDUM, *supra* note 41, at 13 (“[E]nrollees who consider alternative sources of covered care to be unsatisfactory substitutes may forgo care entirely, either because they are unable to pay for psychiatric hospital care themselves or because they choose not to do so.”).

⁴⁶ *See* CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH & HUMAN SERVS., MEDIGAP COVERAGE OF OUTPATIENT MENTAL HEALTH SERVICES THAT ARE SUBJECT TO THE MENTAL HEALTH PAYMENT REDUCTION 3 (2002) [hereinafter MEDIGAP COVERAGE].

⁴⁷ Although no health insurance-related federal statute or regulation defines “co-insurance,” it may be defined as the insured’s liability after the insurer has paid its portion of the total healthcare costs. *See id.* at 2, 6 n.ix (defining co-insurance without reference to a statute or regulation and with respect to common parlance; that is, the beneficiary’s liability after Medicare payment is made).

⁴⁸ *See* 42 U.S.C. § 1395l(c) (2006 & Supp. IV 2010) (calculating as Medicare-incurred expenses only 62.5% of the outpatient expenses associated with the treatment of mental, psychoneurotic, and personality disorders). Until 2010, Medicare was thus responsible for only 50% (i.e., 62.5% x 80% (80% is the Medicare approved amount)) of the cost of most outpatient mental health services, and the Medicare beneficiary was responsible for the remaining 50%. In 2008, President George W. Bush signed into law the Medicare Improvements for Patients and Providers Act of 2008, section 102 of which increased Medicare’s portion of incurred expenses for outpatient mental health services to 68.75% in 2010 and 2011 (resulting in a 45% beneficiary co-insurance in those years), 75% in 2012 (resulting in a 40% beneficiary co-insurance), 81.25% in 2013 (resulting in a 35% beneficiary co-insurance), and 100% in 2014 and thereafter (resulting in a 20% co-insurance). By 2014, Medicare thus will pay 80% of (and Medicare beneficiaries will pay a 20% co-insurance on) all outpatient mental health services. Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 102, 122 Stat. 2494, 2498 (“Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services.”).

⁴⁹ *See* 42 U.S.C. § 1395l(c).

⁵⁰ *See, e.g.,* Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981) (“An individual is entitled to Medicaid if he fulfills the criteria established by the state in which he lives.”); *Overview Medicaid Program—General Information*, CTRS. MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH & HUMAN SERVS., http://www.cms.gov/medicaidgeninfo/01_overview.asp (last updated Nov. 25, 2011) [hereinafter *Medicaid Program*].

institution for mental disease (IMD),⁵¹ defined as a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental disease.⁵² Medicaid also does not cover mental healthcare provided in small residential facilities, including halfway houses, adult residential foster homes, and crisis centers.⁵³ Due to these limitations, many Medicaid beneficiaries are limited to: (1) Medicaid-covered outpatient mental healthcare, which may be insufficiently intense to treat an acute illness episode and may result in suicide or other poor outcomes; (2) Medicaid-covered inpatient care provided in a facility other than an IMD or a small residential facility by clinicians who may lack the education, training, and experience necessary to treat complex psychiatric conditions; or (3) non-covered inpatient care provided in an IMD or small residential facility for which the beneficiary must pay entirely out of pocket.⁵⁴ Because Medicaid eligibility generally requires evidence of low income,⁵⁵ most Medicaid beneficiaries will not be able to pay 100% of the cost of treatment in an IMD or small residential facility.⁵⁶

B. INFERIOR PRIVATE HEALTH INSURANCE BENEFITS

Private health insurers also have a long history of providing less comprehensive insurance benefits to individuals with mental illness.⁵⁷ Traditionally, many private insurers did not cover mental illness.⁵⁸ Notwithstanding the efforts of mental health parity advocates,⁵⁹ neither the Federal Mental Health Parity Act of 1996 (MHPA)⁶⁰

⁵¹ See 42 C.F.R. § 435.1009(a)(2) (2006) (prohibiting Medicaid coverage of healthcare services provided to individuals under age sixty-five who are patients in an institution for mental disease).

⁵² See 42 U.S.C. § 1396d(i) (2006 & Supp. IV 2010) (defining institution for mental disease).

⁵³ See, e.g., Carl A. Taube, Howard H. Goldman & David Salkever, *Medicaid Coverage for Mental Illness: Balancing Access and Costs*, 9 HEALTH AFF. 5, 8 (1990).

⁵⁴ See generally MEDIGAP COVERAGE, *supra* note 46 *passim*.

⁵⁵ See, e.g., *Medicaid Program*, *supra* note 50.

⁵⁶ Costs of inpatient care provided in a psychiatric setting can exceed \$1000 per day in a public facility and \$2000 per day in a private facility. See, e.g., Meg Kissinger, *Mental Facility's Size Cost Taxpayers Million*, MILWAUKEE WIS. J. SENTINEL (Nov. 13, 2010), <http://www.jsonline.com/watchdog/watchdogreports/107835219.html> (stating that the cost of inpatient care at Milwaukee County Mental Health Complex, a public psychiatric hospital located in Milwaukee, Wisconsin, is \$1082 per day); *\$58,752 for 18 Days of Involuntary Commitment to Mental Hospital*, BIPOLAR: CRAZY MERMAID'S BLOG (Aug. 14, 2010), <http://crazymer1.wordpress.com/2010/08/14/58752-for-18-days-of-involuntary-commitment-to-mental-hospital/> (stating that the cost of inpatient care at Fairfax Hospital, a private psychiatric hospital located in Kirkland, Washington, is between \$2468 and \$3900 per day).

⁵⁷ See, e.g., Colleen L. Barry et al., *Design of Mental Health Benefits: Still Unequal After All These Years*, 22 HEALTH AFF. 127, 127 (2003) [hereinafter Barry et al., *Still Unequal*] (presenting health insurance data from a national employer survey; finding that, even after the implementation of the Mental Health Parity Act of 1996, private employer-sponsored mental health insurance coverage is less comprehensive than non-mental health insurance coverage).

⁵⁸ SURGEON GENERAL REPORT, *supra* note 37, at 418 (“Some private insurers refused to cover mental illness treatment . . .”).

⁵⁹ Mental health parity advocates support the financing of mental healthcare on the same basis as the financing of physical healthcare. See, e.g., *id.* at 426 (describing the concept of mental health parity and explaining that “[t]he 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”). See generally Dana L. Kaplan, *Can Legislation Alone Solve America's Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J. 325, 328 (2005) (describing the mental health parity movement).

nor the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)⁶¹ discussed in Parts III.A and III.B, *infra*, required private insurers to offer insurance benefits for mental illness.⁶² Before President Obama signed ACA into law and unless otherwise prohibited by state law, private health insurers were permitted to sell individual policies and group health plans that contained benefits for illnesses traditionally classified as physical, such as cancer and pregnancy, but that did not contain benefits for illnesses traditionally classified as mental, including major depression and bipolar disorder.⁶³ Under ACA, mental health and substance use disorder benefits must be part of the EHB Package offered in the exchange-offered qualified health plan setting,⁶⁴ the non-exchange individual health plan setting, the non-exchange small group health plan setting, the Medicaid benchmark and benchmark-equivalent plan setting, and the state basic health plan setting.⁶⁵ However, as discussed in more detail in Part III.C, *infra*, the EHB Package is not required to be provided by grandfathered health plans, large group health plans (at least until 2017, when ACA permits the exchanges to open to large employers), self-insured group health plans, or traditional Medicaid.⁶⁶ Even after the full implementation of healthcare reform, then, millions of insureds still will not have a federal legal right to a mandatory mental health and substance use disorder benefit.⁶⁷

Prior to ACA, some health plans voluntarily included insurance benefits for mental illness; however, many of these plans imposed higher cost-sharing requirements and greater administrative restrictions on mental health coverage, including higher deductibles, co-payments, and co-insurance amounts for mental healthcare, as well as lower inpatient day and outpatient visit limitations and annual and lifetime spending caps for mental healthcare.⁶⁸ Although MHPAEA requires

⁶⁰ Mental Health Parity Act (MHPA), Pub. L. No. 104-204, 110 Stat. 2944 (1996) (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)).

⁶¹ Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, 122 Stat. 3881 (codified as amended at 29 U.S.C. § 1185a and 42 U.S.C. § 300gg-26).

⁶² See 29 U.S.C. § 1185a(b)(1) (“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.”); 42 U.S.C. § 300gg-26(b)(1).

⁶³ See 29 U.S.C. § 1185a(b)(1); 42 U.S.C. § 300gg-26(b)(1). Some states do require individual and group health plans to include mental health benefits in their health plans. See, e.g., ALA. CODE § 27-54-4(a)(1) to (8) (2010) (requiring all group health plans to include insurance benefits for a range of mental illnesses, including schizophrenia, bipolar disorder, panic disorder, obsessive-compulsive disorder, major depressive disorder, anxiety disorders, and mood disorders); HAW. REV. STAT. § 431M-2 (2010) (requiring all individual and group health plans to include insurance benefits for mental illness as well as alcohol and drug dependency).

⁶⁴ A health insurance exchange is a competitive insurance marketplace where individuals and small businesses can purchase affordable and qualified health benefit plans beginning on or after January 1, 2014. See *Provisions of the Affordable Care Act, by Year*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/timeline/full.html> (last visited Nov. 3, 2011). Exchange-offered health plans must include the EHB Package, defined to include mental health and substance use disorder benefits, by the same date. See ACA, Pub. L. No. 111-148, § 1302(b)(1)(E), 124 Stat. 119 (2010), codified at 42 U.S.C.A. § 18022 (West 2012); *Essential Health Benefits*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/e/essential.html> (last visited Nov. 3, 2011).

⁶⁵ See EHB BULLETIN, *supra* note 23, at 1 (listing the health plan settings that must comply with ACA’s essential health benefits requirement); CONSENSUS REPORT, *supra* note 17, at 6 box S-1, 18.

⁶⁶ See CONSENSUS REPORT, *supra* note 17, at 18-20.

⁶⁷ See *infra* Part III.C.

⁶⁸ See, e.g., SURGEON GENERAL REPORT, *supra* note 37, at 426-27 (summarizing typical mental health benefit disparities that existed in 1997: “the most common insurance restriction was an annual limit on inpatient days . . .”); Barry, *Political Evolution*, *supra* note 37, at 186 (“In 1982, 31% of full-

parity between physical health benefits and mental health benefits in terms of deductibles, co-payments, co-insurance, inpatient day limitations, and outpatient visit limitations,⁶⁹ as discussed below in Part III.B, MHPAEA initially regulated only large group health plans, not small group health plans.⁷⁰ As enacted, MHPAEA also did not apply to individual health insurance policies sold in the private market, the Medicare Program, Medicaid non-managed care plans, or any self-funded non-federal governmental group plan whose sponsor has opted out of MHPAEA.⁷¹ Before ACA and unless otherwise prohibited by state law, many public healthcare programs and private health plans thus were permitted to contain disparate mental health benefits.⁷² Although ACA broadened the application of MHPA, as expanded by MHPAEA, from just the large group health plan setting to the exchange-offered qualified health plan setting and the Medicaid benchmark and benchmark-equivalent plan setting,⁷³ some non-exchange plans continue to be exempt from MHPA as expanded by MHPAEA and ACA (collectively, “federal mental health parity law”). The Medicare Program and traditional fee-for-service Medicaid also continue to be exempt from federal mental health parity law, as are self-funded, non-federal governmental plans whose sponsors have opted out of federal mental health parity law.⁷⁴ Even after the full implementation of healthcare reform, then, many public healthcare program beneficiaries and some individuals with private health insurance still will not have a federal legal right to equal physical health and mental health insurance benefits.⁷⁵

time employees with mental health benefits in medium and large private firms were subject to separate inpatient day limits, and 19% had separate outpatient visit limits. By 2002, 77% had separate inpatient day limits, and 75% had separate outpatient visit limits”); Kaplan, *supra* note 59, at 329 (summarizing mental health benefit disparities that existed in the context of employer-sponsored health plans in 1988); Keith Nelson, *Legislative and Judicial Solutions for Mental Health Parity: S. 543, Reasonable Accommodation, and an Individualized Remedy Under Title I of the ADA*, 51 AM. U. L. REV. 91, 93, 99 (2001) (discussing typical private plan limitations on mental health insurance benefits).

⁶⁹ See *infra* Part III.B.

⁷⁰ See *infra* Part III.B.

⁷¹ See *infra* Part III.B.

⁷² Some states do require small group health plans and individual health insurance policies to establish parity between physical and mental health benefits in terms of deductibles, co-payments, co-insurance, inpatient day limitations, and outpatient visit limitations. See, e.g., 24 ME. REV. STAT. tit. 24, § 2325-A(5-C)(B)(1) (2010) (requiring health insurance policies issued in Maine to provide insurance benefits for the diagnosis and treatment of mental illness under terms and conditions that are no less extensive than the benefits provided for treatment of physical illness); *id.* § 2325-A(5-C)(B)(4) (prohibiting health insurance policies issued in Maine from containing separate maximums for physical and mental illness, separate deductibles and co-insurance amounts for physical illness and mental illness, separate out-of-pocket limits for physical illness and mental illness, or separate office visit limits for physical illness and mental illness); MD. CODE ANN., INS. § 15-802(c) (West 2012) (requiring individual and group health insurance policies issued in Maryland to provide benefits for the diagnosis and treatment of mental illness under the same terms and conditions that apply under the policy or contract for the diagnosis and treatment of physical illness).

⁷³ See *infra* Part III.C.

⁷⁴ See *infra* Parts III.A-C.

⁷⁵ See *infra* Parts III.A-C.

III. FEDERAL MENTAL HEALTH PARITY AND MANDATORY MENTAL
 HEALTH AND SUBSTANCE USE DISORDER BENEFITS: LAWS,
 RECOMMENDATIONS, AND PROPOSALS⁷⁶

A. THE MENTAL HEALTH PARITY ACT OF 1996

In an attempt to remedy some of the historically inferior health insurance benefits available to individuals with mental illness, the federal government took its first step towards establishing mental health parity on September 26, 1996, when President Bill Clinton signed the Federal Mental Health Parity Act into law.⁷⁷ In terms of application, MHPA was very limited. As originally enacted, the statute only regulated insured and self-insured group health plans of large employers, defined as those employers that employ an average of fifty-one or more employees.⁷⁸ MHPA thus did not apply to the group health plans of small employers.⁷⁹ MHPA also did not apply to individual health plans, the Medicare Program, Medicaid non-managed care plans, or any self-funded, non-federal governmental plan whose sponsor opted out of MHPA.⁸⁰ Finally, MHPA contained an “increased cost” exemption for covered group health plans or health insurance coverage offered in connection with such plans if the application of MHPA resulted in an increase in the cost under the

⁷⁶ Parts III.A-C of this Article are reprinted with updates and minor changes with permission from Tovino, *supra* note 2, at pts. II.A-C. Parts III.D-E of this Article are new.

⁷⁷ See MHPA, Pub. L. No. 104-204, 110 Stat. 2944 (1996).

⁷⁸ See *id.* § 712(a)(1), (2) (applying in each case to “a group health plan (or health insurance coverage offered in connection with such a plan . . .)”).

⁷⁹ 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 two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year).

⁸⁰ See, e.g., The Mental Health Parity and Addiction Equity Act, CTRS. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS. (last visited April 3, 2010) [hereinafter The Mental Health Parity and Addiction Equity Act] (“MHPAEA does not apply to small group health plans.”); *id.* (“Medicare Medicaid are not issuers of health insurance. They are public health plans through which individuals obtain health coverage. . . . Medicaid Benchmark Benefit plans [however] . . . are subject to certain requirements of MHPAEA.”); *id.* (“Non-Federal governmental employers that provide self-funded group health plan coverage to their employees (coverage that is not provided through an insurer) may elect to exempt their plan (opt-out) from the requirements of MHPAEA”); Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 407 (2010) [hereinafter Barry et al., *Political History*] (explaining that the MHPAEA applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care, the State Children’s Health Insurance Program, and state and local government plans, but not Medicaid non-managed care plans); Letter from Cindy Mann, Dir. of the Ctr. for Medicaid and CHIP Servs. (CMCS), Ctrs. for Medicare & Medicaid Servs., Dep’t of Health & Human Servs., to State Health Officials 2 (Nov. 4, 2009), available at <https://www.cms.gov/SMDL/downloads/SHO110409.pdf> (“The MHPAEA requirements apply to Medicaid only insofar as a State’s Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs), to provide medical/surgical benefits as well as mental health or substance use disorder benefits MHPAEA parity requirements do not apply to the Medicaid State plan if a State does not use MCOs or PIHPs to provide these benefits.”); 42 U.S.C. § 300gg-21(a)(2)(A) (2006 & Supp. IV 2010) (permitting sponsors of self-insured non-federal governmental health plans to opt out of particular federal requirements); 45 C.F.R. § 146.180(a)(1)(v) (2011) (permitting sponsors of self-insured non-federal governmental health plans to opt out of federal mental health parity requirements); Memorandum from Steve Larsen, Dir. of Oversight, Dep’t of Health & Human Servs. 2 (Sept. 21, 2010) (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: “[p]rovisions 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)”).

plan of at least one percent.⁸¹ By November 1998, over two years following MHPA's enactment, only four plans across the United States had obtained exemptions due to cost increases of one percent or more.⁸²

In terms of its substantive provisions, MHPA was neither a mandated offer nor a mandated benefit law; that is, nothing in MHPA required a covered large group health plan to actually offer or provide any mental health benefits.⁸³ As originally enacted, MHPA also was not a comprehensive parity law because it neither protected individuals with substance use disorders⁸⁴ nor required parity between physical and mental health benefits in terms of deductibles, co-payments, co-insurance, inpatient day limitations, or outpatient visit limitations.⁸⁵

As originally enacted, what MHPA did do was regulate lifetime and annual spending limits that covered group health plans applied to mental health benefits if such plans already offered both physical and mental health benefits.⁸⁶ More specifically, if a covered group health plan did not impose an aggregate lifetime or annual limit on substantially all physical health benefits, the plan was prohibited from imposing an aggregate lifetime or annual limit on offered mental health benefits.⁸⁷ If a covered group health plan did impose an aggregate lifetime or annual limit on substantially all physical health benefits, the plan was required to 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, the plan was prohibited from imposing any aggregate lifetime or annual limit on mental health benefits that was less than the applicable lifetime or annual limit imposed on physical health benefits.⁸⁸ MHPA (and, as discussed in Part III.C, *infra*, ACA) thus would prohibit a covered group health plan from imposing a \$20,000 annual cap or a \$100,000 lifetime cap on mental healthcare if the plan had no annual or lifetime caps for physical healthcare or if the plan had higher caps, such as a \$50,000 annual cap or a \$500,000 lifetime cap, for physical healthcare.

B. THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

Twelve years after President Clinton signed MHPA into law, President George W. Bush expanded federal mental health parity law by signing into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.⁸⁹ In terms of application, MHPAEA also was very limited. As originally

⁸¹ MHPA, Pub. L. No. 104-204, § 712(c)(2), 110 Stat. 2944 (1996).

⁸² Barry et al., *Political Evolution*, *supra* note 37, at 187.

⁸³ See MHPA § 712(b)(1) (“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 . . .”).

⁸⁴ See *id.* § 712(e)(4) (“The term ‘mental health benefits’ means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.”).

⁸⁵ See *id.* § 712(b)(2) (“Nothing in this Section shall be construed . . . as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage . . .”).

⁸⁶ See *id.* § 712(a)(1)-(2).

⁸⁷ See *id.* § 712(a)(1)(A) (no aggregate lifetime limits); *id.* § 712(a)(2)(A) (no annual limits).

⁸⁸ See *id.* § 712(a)(1)(B) (aggregate lifetime limits); *id.* § 712(a)(2)(B) (annual limits).

⁸⁹ See MHPAEA, Pub. L. No. 110-343, 122 Stat. 3881 (2008) (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)).

enacted, MHPAEA (like MHPA) only regulated insured and self-insured group health plans of large employers, defined as those employers that employ an average of fifty-one or more employees.⁹⁰ MHPAEA (like MHPA) thus did not apply to small group health plans, individual health plans, the Medicare Program, Medicaid non-managed care plans, or any self-funded, non-federal governmental plans whose sponsor opted out of MHPAEA.⁹¹ In terms of its substantive provisions, MHPAEA also was neither a mandated offer nor a mandated benefit law; that is, nothing in MHPAEA required a covered group health plan to actually offer or provide any mental health benefits.⁹² Like MHPA, MHPAEA also contained an “increased cost” exemption for covered group health plans and health insurance coverage offered in connection with such plans, but under MHPAEA the amount of the required cost increase increased, at least for the first year.⁹³ That is, a covered plan that could demonstrate a cost increase of at least two percent in the first plan year and one percent in each subsequent plan year of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits would be eligible for an exemption from MHPAEA for such year.⁹⁴ MHPAEA required determinations of exemption-qualifying cost increases to be made and certified in writing by a qualified and licensed actuary who in good standing belongs to the American Academy of Actuaries.⁹⁵

Notwithstanding these limitations and exemptions, MHPAEA built on MHPA by protecting individuals with substance use disorders⁹⁶ and by imposing comprehensive parity requirements on covered group health plans. In particular, MHPAEA required financial requirements (including deductibles, co-payments, co-insurance, and other out-of-pocket expenses)⁹⁷ and treatment limitations (including inpatient day and outpatient visit limitations)⁹⁸ that covered group health plans imposed on mental health and substance use disorder benefits to be no more restrictive than the predominant financial requirements and treatment limitations imposed on substantially all physical health benefits.⁹⁹ MHPAEA thus prohibited covered group health plans from imposing higher deductibles, co-payments, or co-

⁹⁰ *Id.* § 512(a)(1) (applying only to group health plans or health insurance coverage offered in connection with such plans).

⁹¹ *See supra* note 80.

⁹² *See* MHPAEA § 512(a)(1) (regulating only those group health plans that offer both physical health and mental health benefits); The Mental Health Parity and Addiction Equity Act, *supra* note 80 (stating, “MHPAEA does not require large group health plans and their health insurance issuers to cover MH/SUD [mental health and substance use disorder] benefits. The law’s requirements apply only to large group health plans and their health insurance issuers that choose to include MH/SUD benefits in their benefit packages.”).

⁹³ *See* MHPAEA § 512(a)(3) (establishing new cost exemption provisions).

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *See id.* § 512(a)(4) (adding a new definition of “substance use disorder benefits”); *id.* § 512(a)(1) (regulating the financial requirements and treatment limitations that are applied to both mental health and substance use disorder benefits).

⁹⁷ *See id.* § 512(a)(1) (including within the definition of “financial requirements” deductibles, co-payments, co-insurance, and out-of-pocket expenses).

⁹⁸ *See id.* (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).

⁹⁹ *See id.* (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).

insurances, or lower inpatient day and outpatient visit maximums, on individuals who were seeking care for conditions—such as bipolar disorder, schizophrenia, alcohol abuse, and drug abuse—compared to individuals who were seeking care for traditional physical conditions—such as pregnancy, cancer, and orthopedic injuries. On February 2, 2010, the Departments of Treasury, Labor, and HHS co-released an interim final rule implementing MHPAEA’s requirements.¹⁰⁰ The interim final rule clarified in favor of patients with mental health conditions several questions that MHPA and MHPAEA had left open, including the question whether a covered group health plan could impose separately accumulating financial requirements or quantitative treatment limitations on mental health and substance use disorder benefits (“No”),¹⁰¹ and the question whether a covered group health plan could impose a non-quantitative treatment limitation (including a medical necessity limitation or an experimental/investigative limitation) on mental health and substance use disorder benefits (also “No”).¹⁰²

C. THE AFFORDABLE CARE ACT OF 2010

Before healthcare reform, mental health insurance benefits thus were regulated by MHPA as expanded by MHPAEA as well as by more stringent state law.¹⁰³ In March 2010, President Obama further expanded mental health parity and mental health and substance use disorder benefit law by signing ACA into law.¹⁰⁴ Best known for its controversial (and constitutionally challenged) individual health insurance mandate,¹⁰⁵ ACA has buried within it several provisions that relate to mental health parity and mandatory mental health and substance use disorder benefits. If upheld,¹⁰⁶ these provisions will extend mental health parity law and create a mandatory mental health and substance use disorder services requirement in a way that will benefit additional (but not all) groups of individuals with public and private health insurance.

The first ACA provision that is relevant to mental health parity law 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

¹⁰⁰ Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5410-51 (Feb. 2, 2010).

¹⁰¹ *See id.* at 5449 (revising 45 C.F.R. § 46.136(c)(3)(v) to clarify that covered group health plans may not apply cumulative financial requirements or cumulative quantitative treatment limitations for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical or surgical benefits in the same classification).

¹⁰² *See id.* (revising 45 C.F.R. § 46.136(c)(4)(i) and (ii) to clarify that a covered group health plan may not impose a non-quantitative treatment limitation on mental health and substance use disorder benefits unless the processes used in applying the treatment limitation are comparable to, and are applied no more stringently than, the processes used in applying the same limitation on medical and surgical benefits).

¹⁰³ *See* Tovino, *supra* note 4, at pts. I.A-I.D (describing the patchwork of state mental health parity law and providing examples of state laws that are more and less stringent than federal law).

¹⁰⁴ ACA, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

¹⁰⁵ *Id.* § 1501(a) (adding to the Internal Revenue Code: “[a]n 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”).

¹⁰⁶ *See, e.g.,* Florida v. U.S. Dep’t of Health and Human Servs., 648 F.3d 1235 (11th Cir. 2011), *cert. granted sub nom.* Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 603 (2011) (mem.), *and cert. granted*, 132 S. Ct. 604 (2011) (No. 11-398) (mem.) (argued Mar. 26-27, 2012), *and cert. granted in part*, 132 S. Ct. 604 (2011) (No. 11-400) (mem.) (argued Mar. 28, 2012).

health insurance issuers and group health plans.”¹⁰⁷ Section 2726 of the PHSa is the parallel citation to 42 U.S.C. § 300gg-26, the section within the United States Code where the non-ERISA provisions of MHPA as amended by MHPAEA are codified.¹⁰⁸ The dramatic effect of this provision is to expand the application of MHPA and MHPAEA from just large group health plans to all qualified health plans that are offered on one of the new ACA-created state or regional health insurance exchanges beginning on or after January 1, 2014.¹⁰⁹ The second relevant ACA provision makes conforming and technical changes to PHSa section 2726 to clarify the expansion of MHPA and MHPAEA to individual health insurance coverage.¹¹⁰ As a result of these two provisions, many individual and small group health plans that were previously exempt from MHPA and MHPAEA now are prohibited from offering inferior mental health insurance benefits, including through higher deductibles, co-payments, and co-insurance rates, as well as lower inpatient day and outpatient visit limitations.

A third relevant ACA provision prevents 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.¹¹¹ 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,¹¹² mental health and substance use disorder benefits,

¹⁰⁷ ACA § 1311(j) (entitled “Applicability of Mental Health Parity”).

¹⁰⁸ 42 U.S.C.A. § 300gg-26 (West 2012) (entitled “Parity in Mental Health and Substance Use Disorder Benefits”).

¹⁰⁹ ACA § 1311(j) (“[MHPAEA] 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.”). Compare the former MHPAEA, Pub. L. No. 110-343, 122 Stat. 3881 (2008) (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)) (making its provisions applicable to “group health plans or health insurance coverage offered in connection with such a plan”), with the newly amended 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”).

¹¹⁰ ACA § 1563(c)(4) (identifying the conforming and technical changes that will be made to former 42 U.S.C. § 300gg-5 (current 42 U.S.C. § 300gg-26)); Historical and Statutory Notes for former 42 U.S.C. § 300gg-5 (noting that former 42 U.S.C. § 300gg-5 was transferred to 42 U.S.C. § 300gg-26); *see also* EHB BULLETIN, *supra* note 23, at 12 (“The Affordable Care Act also specifically extends MHPAEA to the individual market.”).

¹¹¹ ACA § 10101 (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. *Id.* 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. 26 C.F.R. § 54.9815-2711T. ACA prohibits annual limits on essential benefits beginning January 1, 2014. *See* ACA § 10101 (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.”); 26 C.F.R. § 54.9815-2711T (2010). *See generally* *Lifetime & Annual Limits*, HEALTHCARE.GOV, <http://www.healthcare.gov/law/features/costs/limits/index.html> (last visited Mar. 3, 2012) (explaining the new lifetime and annual limit prohibitions and restrictions).

¹¹² ACA § 10101 (adding new PHSa § 2711(b)).

including behavioral health treatments, are considered essential health benefits¹¹³ and thus are excepted from the right of reservation. This third ACA provision builds on the original MHPA, which allowed lifetime and annual limits but only so long as such limits that applied to treatment of mental health conditions were not lower than those that applied to treatment of physical health conditions.¹¹⁴ Now, ACA prohibits all lifetime as well as most annual limits.¹¹⁵

Perhaps most importantly, a fourth set of ACA provisions mandates mental health and substance use disorder benefits in certain plan settings. Under section 1201 of ACA, a health insurance issuer that offers health insurance coverage in the individual or small group markets shall ensure that such coverage includes the EHB Package required by section 1302 of ACA.¹¹⁶ Under section 1301 of ACA, qualified health plans that will be offered on the new ACA-created health insurance exchanges also must provide the EHB Package required by section 1302 of ACA.¹¹⁷ Under section 1331 of ACA, the optional state basic health plans¹¹⁸ also must provide the EHB Package required by section 1302 of ACA.¹¹⁹ Finally, under section 2001 of ACA, Medicaid benchmark plans and benchmark-equivalent plans also must provide the EHB Package required by section 1302 of ACA.¹²⁰ Under the quadruple-referenced section 1302 of ACA, the EHB Package includes “mental health and substance use disorder services, including behavioral health treatment.”¹²¹ Read together, these four ACA provisions are significant. Federal law for the first time is mandating mental health and substance use disorder benefits in certain plan settings; that is, the non-exchange individual health plan, the non-exchange small group health plan, the exchange-offered qualified health plan, the state basic health plan, and the Medicaid benchmark and benchmark-equivalent plan settings.¹²²

Under regulations co-published by the Departments of Treasury, Labor, and HHS on June 17, 2010, the Departments clarified, however, that the essential health

¹¹³ ACA § 1302(b)(1)(E) (including mental health and substance use disorder services, including behavioral health treatment, within the definition of essential health benefits).

¹¹⁴ See *supra* Part III.A.

¹¹⁵ HEALTHCARE.GOV, *supra* note 111 (“The ban on lifetime dollar limits for most covered benefits applies to every health plan—whether you buy coverage for yourself or your family, or you receive coverage through your employer.”).

¹¹⁶ ACA § 1201 (adding new PHSA § 2707(a), to be codified at 42 U.S.C. § 300gg-6(a)).

¹¹⁷ *Id.* § 1301(a)(1)(B) (adding new 42 U.S.C. § 18021(a)(1)(B)).

¹¹⁸ Individuals eligible for state basic health plan coverage include individuals who are not eligible for Medicaid and whose household income falls between 133 and 200 percent of the federal poverty level for the family involved as well as low-income legal resident immigrants. *Id.* § 1331(e).

¹¹⁹ *Id.* § 1331(a)(1) (requiring state basic health plans to provide “at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange”).

¹²⁰ *Id.* § 2001(c)(3) (adding new 42 U.S.C. § 1396u-7(b)(5)).

¹²¹ *Id.* § 1302(b)(1)(E) (“[E]ssential health benefits . . . shall include . . . [m]ental health and substance use disorder services, including behavioral health treatment.”); Pamela S. Hyde, *The Affordable Care Act and Mental Health: An Update*, HEALTHCARE.GOV (Aug. 19, 2010), <http://www.healthcare.gov/blog/2010/08/mentalhealthupdate.html> (“[I]n 2014, mental health and substance use disorder services will be part of the essential benefits package, a set of health care service categories that must be covered by certain plans, including all insurance policies that will be offered through the Exchanges, and Medicaid.”).

¹²² See *id.*; see also EHB BULLETIN, *supra* note 24, at 1 (listing the health plan settings regulated by ACA’s EHB requirement); CONSENSUS REPORT, *supra* note 17, at 7 box S-1, 18-23 (listing the health plan settings regulated by ACA’s EHB requirement); *Essential Health Benefits*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/e/essential.html> (last visited Mar. 1, 2012) (“Insurance policies must cover these [essential health] benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services by 2014.”).

benefit requirement does not apply to grandfathered health plans.¹²³ 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 the Patient Protection and Affordable Care Act (PPACA) into law.¹²⁴ 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.¹²⁵ 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 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;¹²⁶ and (iv) entering into a new policy, certificate or contract of insurance (that is, changing insurance carriers) after March 23, 2010.¹²⁷ Activities that will cause a grandfathered plan to lose

¹²³ 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)) (“[T]he provisions of PHS Act sections . . . 2707 . . . do not apply to grandfathered health plans.”); EMP. BENEFITS SEC. ADMIN., U.S. 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) (explaining that ACA’s essential benefit package requirement is not applicable to grandfathered plans).

¹²⁴ 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. at 34562 (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”).

¹²⁵ *Id.* at 34541 (defining grandfathered plans and identifying the ways in which grandfathered plans can lose grandfathered status, turning them into non-grandfathered plans).

¹²⁶ *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), 29 C.F.R. § 2590.715-1251(a)(4) (addition of new family members), and 29 C.F.R. § 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 (2011), *available at* http://assets.opencrs.com/rpts/R41166_20110103.pdf (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”).

¹²⁷ 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. at 34562 (adding new 29 C.F.R. § 2950.715-1251(a)(1)(ii) (“[I]f 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.”); 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”); 29 C.F.R. § 2950.715-1251(a)(1)(i) (stating “Subject 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 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 co-payments; (iv) certain increases in fixed-amount co-payments; (v) certain decreases in contribution rates by employers and employee organizations; and (vi) certain changes in annual limits.¹²⁸ The Department of Treasury predicts that forty-nine to eighty percent of small employer plans and thirty-four to sixty-four percent of large employer plans will relinquish grandfathered status by the end of 2013.¹²⁹

Understanding the distinction between grandfathered and non-grandfathered plans is the key to understanding the application of ACA's health insurance reforms, including the EHB Provision. Grandfathered health plans are exempt from the vast majority of new insurance reforms required by ACA,¹³⁰ including newly added section 2707 of the Public Health Service Act, codified at 42 U.S.C. § 300gg-26, which requires health insurance issuers that offer health insurance coverage in the individual and small group markets to ensure that such coverage includes the EHB Package.¹³¹ The result (in terms of mandated benefits) is that grandfathered health plans are regulated only by MHPA and MHPAEA, neither of which contains a mandated mental health or substance use disorder benefit,¹³² as well as state law, which may or may not contain a mandated mental health and substance use disorder benefit.¹³³ Grandfathered health plans are not the only health plans that are exempt

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 new contract with a new issuer or a new policy is issued with an existing insurer)").

¹²⁸ 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. at 34564-65 (adding new 29 C.F.R. § 2590.715-1251(g)(1) (listing the changes that will cause cessation of grandfathered status)).

¹²⁹ *Id.* at 34552.

¹³⁰ *See, e.g., id.* at 34540 (“[C]ertain group health plans and health insurance coverage existing as of March 23, 2010 . . . , are subject only to certain provisions of the Affordable Care Act.”); FERNANDEZ, *supra* note 126, at 1 (“Grandfathered health plans are exempt from the vast majority of new insurance reforms under PPACA.”).

¹³¹ ACA, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (amending section 2707(a) of the PHS Act and stating that “[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 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. at 34559 (explaining that section 2707 of the PHS Act does not apply to grandfathered health plans); 29 C.F.R. § 2590.715-1251(c)(1) (“[T]he provisions of PHS Act section[] . . . 2707 . . . do[es] not apply to grandfathered health plans.”); EMP. BENEFITS SEC. ADMIN., *supra* note 123 (explaining that ACA's essential benefit package requirement does not apply to grandfathered plans); CONSENSUS REPORT, *supra* note 17, at 18 (explaining that ACA's EHB requirement does not apply to grandfathered health plans).

¹³² *See, e.g.,* 29 U.S.C.A. § 1185a(b)(1) (West 2012) (“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 or substance use disorder benefits”); 42 U.S.C.A. § 300gg-26(b)(1) (West 2012) (“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”).

¹³³ *See, e.g.,* Tovino, *supra* note 4, at pts. I.A-I.D (discussing different state approaches to mandatory mental health and substance use disorder benefits).

from the EHB requirement.¹³⁴ The EHB requirement also does not apply in the large group health plan setting (at least until 2017, when ACA permits the exchanges to open to large employers), the self-insured group health plan setting, and the traditional Medicaid setting.^{135,136}

D. THE INSTITUTE OF MEDICINE'S WORKSHOP AND CONSENSUS REPORTS OF 2011

Section 1302 of ACA requires the Secretary to define the EHB Package.¹³⁷ Among other requirements, ACA further specifies that the Secretary shall: (1) ensure that the scope of the EHB Package is equal to the scope of benefits provided under a typical employer plan;¹³⁸ (2) ensure that the EHB Package reflects an appropriate balance among the categories so that the benefits are not unduly weighted toward any category;¹³⁹ (3) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;¹⁴⁰ (4) take into account the healthcare needs of diverse segments of the population, including women, children, persons with disabilities, and other groups,¹⁴¹ and (5) periodically review the EHB Package and provide a report to Congress and the public assessing whether the EHB needs to be modified or updated.¹⁴²

Following ACA's enactment, HHS requested guidance from the IOM on the criteria and methods that should be used to determine and update the EHB Package.¹⁴³ To assist the Secretary with her responsibilities under ACA, the IOM formed the Committee.¹⁴⁴ The Committee was not charged with identifying the individual elements or the detailed provisions of the EHB Package; instead, the Committee was asked to develop a framework for considering an EHB Package that

¹³⁴ CONSENSUS REPORT, *supra* note 17, at 18.

¹³⁵ *See id.* at 18-20 (listing the health plan settings to which ACA's EHB requirement does not apply); Sara Rosenbaum, Joel Teitelbaum & Katherine Hayes, *The Essential Health Benefits Provisions of the Affordable Care Act: Implications for People with Disabilities*, 3 COMMONWEALTH FUND 1, 3 (2011) ("The act exempts large-group health plans, as well as self-insured ERISA plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements.").

¹³⁶ According to data on currently marketed health plans, thirty-four percent of individual or family health plan enrollees do not have coverage for substance abuse services and eighteen percent of enrollees do not have coverage for other mental health services. *See* OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, DEP'T HEALTH & HUMAN SERVS., *Essential Health Benefits: Individual Market Coverage*, ASPE ISSUE BRIEF (Dec. 16, 2011) [hereinafter ASPE ISSUE BRIEF], available at <http://aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.shtml>.

¹³⁷ ACA § 1302(a)(1) ("In this title, the term 'essential health benefits package' means, with respect to any health plan, coverage that . . . provides for the essential health benefits defined by the Secretary . . ."); *id.* § 1302(b)(1) ("[T]he Secretary shall define the essential health benefits . . .").

¹³⁸ *Id.* § 1302(b)(2)(A). The Secretary also is responsible for determining the scope of benefits provided by a typical employer plan. To inform her determination, the Secretary was required to take into account a report by the Department of Labor on the scope of benefits offered under employer-sponsored insurance. *See* U.S. DEP'T OF LABOR, *SELECTED MEDICAL BENEFITS: A REPORT FROM THE DEPARTMENT OF LABOR TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES* (2011).

¹³⁹ ACA § 1302(b)(4)(A).

¹⁴⁰ *Id.* § 1302(b)(4)(B).

¹⁴¹ *Id.* § 1302(b)(4)(C).

¹⁴² *Id.* § 1302(b)(4)(G).

¹⁴³ WORKSHOP REPORT, *supra* note 10.

¹⁴⁴ *Id.* at 2.

would be “logically cohesive, address statutory requirements, and serve HHS now and in the future.”¹⁴⁵

The Committee began its work by providing opportunities for the public to comment on the EHB Package through two different venues.¹⁴⁶ First, the Committee requested public comment on ten different Web-distributed questions relating to the EHB Package.¹⁴⁷ Second, the Committee invited a number of speakers to present their views regarding the EHB Package at public workshops held on January 13-14, 2011, in Washington, D.C., and on March 2, 2011, in Costa Mesa, California.¹⁴⁸ The invited speakers included experts from federal and state government, employers, insurers, healthcare providers, consumers, and healthcare researchers.¹⁴⁹ On August 29, 2011, the Committee released the *Workshop Report*, which summarized the speaker presentations from the D.C. and Costa Mesa workshops but did not contain the Committee’s own recommendations regarding the EHB Package.¹⁵⁰ During the workshops, speaker discussion coalesced around several key topics including balancing the generosity of coverage with affordability, balancing specificity versus flexibility in terms of the EHB Package, evaluating existing state benefit mandates for inclusion into the EHB Package, and defining a typical employer plan.¹⁵¹ Because many of the speaker comments—especially those relating to balancing the generosity of coverage with affordability and the desirability of specificity versus flexibility in terms of the EHB Package—are relevant to the analysis and proposal set forth in Part IV of this Article, relevant speaker comments are briefly summarized in Part IV.

On October 7, 2011, the Committee released the *Consensus Report*.¹⁵² In the *Consensus Report*, the Committee concluded that the Secretary should begin simply by defining the EHB Package to reflect the scope and design of packages offered by small employers, modified to include the ten ACA-required EHB categories.¹⁵³ The Committee also identified criteria for the content of the aggregate EHB Package and specific components of the EHB Package,¹⁵⁴ as well as four policy foundations (or domains) that HHS should use in determining the EHB Package, including economics, ethics, population-based health, and evidence-based practice.¹⁵⁵ Like the speaker perspectives captured in the *Workshop Report*, perhaps the most important and recurring concern of the Committee that was expressed in the *Consensus Report* was the perceived tension between the need for comprehensive benefits and the concerns associated with the costs of such benefits.¹⁵⁶

¹⁴⁵ *Id.* at 17.

¹⁴⁶ *Id.* at 1-2.

¹⁴⁷ *Id.* For the list of questions, see *id.* at 161-62.

¹⁴⁸ *Id.* at 1-2.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.* at 3.

¹⁵¹ *Id.* at 2.

¹⁵² CONSENSUS REPORT, *supra* note 17.

¹⁵³ *Id.* at 1.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ See *id.* at xi (“If the package of benefits . . . is too broad, insurance might become too expensive.”); *id.* at 1 (“[T]he more expansive the benefit package is, the more it will likely cost and the less affordable it will be.”); *id.* (“The basic tension [i]s how comprehensive the EHB could be and still be affordable for consumers and payers and sustainable as a program over time.”); *id.* at 87 (“The central debate in constructing the EHB package has been balancing the comprehensiveness of benefits with their costs so as to promote value.”).

In the end, the Committee made five specific sets of recommendations.¹⁵⁷ The Committee's first major set of recommendations related to the establishment of the EHB Package.¹⁵⁸ That is, by May 1, 2012, the Secretary should establish an EHB Package guided by a national average premium target.¹⁵⁹ According to the Committee, the starting point in establishing the initial EHB Package should be the scope of benefits and design provided under a typical small employer plan in today's market.¹⁶⁰ To specify the initial EHB Package, the scope of benefits should then be modified to reflect the ten ACA-required benefit categories as well as additional criteria specified elsewhere in the *Consensus Report* for the content of both the aggregate EHB package and specific components of the EHB Package.¹⁶¹ Importantly, the Committee recommended that section 1302(b)(1) of ACA, which states that "the essential health benefits . . . shall include at least the following general categories and the items and services covered within the categories," not be read to mean that every service that is within one of the ten ACA-required categories or is covered by a typical employer plan should automatically be included within the EHB Package.¹⁶²

Once the Secretary has developed a preliminary EHB Package, the Committee recommends that the package be further adjusted so that the expected national average premium for a silver plan with the EHB Package is actuarially equivalent to the average premium that would have been paid by small employers in 2014 for a comparable population with a typical benefit design.¹⁶³ The Committee finally recommended that the initial guidance provided by the Secretary on the contents of the EHB package should list standard benefit inclusions and exclusions at a level of specificity at least comparable to current best practice in the private and public insurance market.¹⁶⁴

The Committee's second major recommendation was that, by January 1, 2013, the Secretary should establish a framework for obtaining and analyzing data necessary for monitoring implementation of and updating the EHB Package.¹⁶⁵

¹⁵⁷ For a discussion of the five recommendations, see *id.* at 90-149.

¹⁵⁸ *Id.* at 90.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.* For a list of the additional criteria relating to the content of the aggregate EHB package and specific components of the EHB package, see CONSENSUS REPORT, *supra* note 17, at 5 fig.S-2. The Committee recommended that, in the aggregate, the EHB Package be affordable, maximize the number of people with insurance coverage, protect the most vulnerable by addressing the particular needs of those patients and populations, encourage better care practices by promoting the right care to the right patient in the right setting at the right time, advance stewardship of resources by focusing on high value services and reducing use of low value services (with value being defined as outcomes relative to costs), address the medical concerns of greatest importance to enrollees in EHB-related plans, as identified through a public deliberative process, and protect against the greatest financial risks due to catastrophic events or illnesses. See *id.* at 5. The Committee recommended that individual services, devices, and drugs that are part of the EHB Package be safe (i.e., expected benefits should be greater than expected harms), be medically effective and supported by a sufficient evidence base (or, in the absence of evidence on effectiveness, a credible standard of care), demonstrate meaningful improvement in outcomes over current effective services and treatments, be a medical service (and not primarily a social or educational service), and be cost effective (such that the health gain for individual and population health is sufficient to justify the additional cost to taxpayers and consumers). *Id.*

¹⁶² *Id.* at 63.

¹⁶³ *Id.* at 90.

¹⁶⁴ *Id.*

¹⁶⁵ *Id.* at 117.

According to the Committee, the framework should account for changes related to: (1) providers (including payment rates, contracting mechanisms, financial incentives, and scope and organization of practice); (2) patients and consumers (including demographics, health status, disease burden, and problems with access); and (3) health plans (including characteristics of plans such as inclusions, exclusions, and limitations, cost-sharing practices, patterns of enrollment and disenrollment, network configuration, medical management programs, value-based insurance design, and types of external appeals, risk selection, solvency, impact of ACA-mandated limits on deductibles, co-payments, and out-of-pocket spending on the ability of plans to offer acceptable products).¹⁶⁶

The Committee's third major set of recommendations related to state innovation. As background, the health insurance reform provisions within ACA attempt to balance federal and state authority.¹⁶⁷ While federal law regulates certain aspects of the individual and small group markets through various pricing and issuance requirements, states are given relatively broad authority to operate their own exchanges and to regulate other aspects of health insurance.¹⁶⁸ Although ACA clearly states that the Secretary shall define the EHB Package, ACA does not address whether the Secretary is permitted to approve more than one EHB Package definition if the statutory requirements are otherwise satisfied.¹⁶⁹ Because the Committee believes that the Secretary has the authority to approve refinements of the EHB Package definition, if she chooses to do so,¹⁷⁰ the Committee's third major set of recommendations relate to the EHB Package in terms of state innovation. Specifically, for states administering their own exchanges that wish to adopt a variant of the Federal EHB Package, the Committee recommended that the Secretary should use statutory authority to grant such requests, provided that: (1) the state-specific EHB Package definition is consistent with the requirements of section 1302 of the ACA and the Committee's criteria relating to the aggregate and specific content of the EHB package; (2) the state definition produces a package that is actuarially equivalent to the national package established by the Secretary; and (3) each state's variance request is supported by a process that has included meaningful public input.¹⁷¹

The Committee's fourth major set of recommendations related to updating the EHB Package. That is, the Secretary should, beginning in 2015 and annually thereafter, update the EHB Package with the goal of making the EHB Package more fully evidence-based, specific, and value-promoting.¹⁷² The Committee also recommended that the Secretary explicitly incorporate costs into updates to the EHB Package and obtain an actuarial estimate of the national average premium for a silver-level plan with the existing EHB Package in the next year.¹⁷³ According to the Committee, the actuarial estimate should account for trends in medical prices, utilization, new technologies, and population characteristics.¹⁷⁴ Finally, any changes to the EHB Package should not exceed the actuarially estimated cost of the current

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 131-32.

¹⁷² *Id.* at 9-10.

¹⁷³ *Id.* at 10.

¹⁷⁴ *Id.*

package in the next year.¹⁷⁵ To ensure over time that EHB-defined packages are affordable and offer reasonable coverage, the Committee also recommended that the Secretary, working in collaboration with others, develop a strategy for controlling rates of growth in healthcare spending across all sectors in line with the rate of growth in the economy.¹⁷⁶

The Committee's fifth major set of recommendations related to an NBAC. That is, the Secretary should establish an NBAC, staffed by HHS but appointed through a nonpartisan process, such as the Office of the Comptroller General of the United States.¹⁷⁷ The Committee recommended that the NBAC should: (1) by January 1, 2013, advise the Secretary on a research plan and data requirements for updating the EHB Package; (2) starting in 2015 for implementation in 2016, make recommendations annually to the Secretary regarding any changes to the EHB Package by applying the Committee's recommended criteria relating to the aggregate and individual content of the EHB Package, any changes to the premium target, and any mechanisms that would enhance the evidence base of the EHB Package and its potential for promoting value; and (3) advise the Secretary on conducting and using the results of a periodic national public deliberative process to inform its recommendations around updates to the EHB Package.¹⁷⁸

E. THE HHS ESSENTIAL HEALTH BENEFITS BULLETIN OF 2011

Following the release of the *Consensus Report*, HHS held an additional series of "listening sessions" with consumers, providers, employers, plans, state representatives, and other stakeholders in different cities across the United States.¹⁷⁹ During these sessions, some consumer and provider representatives expressed their concern regarding the Committee's emphasis in its *Consensus Report* on cost over comprehensiveness of benefits, the need for the Secretary to spell out specific, uniform benefits in regulations, and the fact that small group plans may not represent the typical employer plan envisioned by ACA.¹⁸⁰ On the other hand, some employer and health insurance representatives expressed their support for a more moderate benefit package, flexibility in the EHB Package across the country to reflect local preferences and practices, and benchmarking the EHB Package to small employer plans.¹⁸¹

On December 16, 2011, HHS released its *Essential Health Benefits Bulletin*.¹⁸² The *EHB Bulletin* provides information and solicits comments on a regulatory approach that HHS plans to propose to define the EHB Package.¹⁸³ More specifically, the *EHB Bulletin* outlines HHS's goal of pursuing an approach that will: (1) encompass the ten ACA-required categories of benefits; (2) reflect typical employer health benefit plans; (3) reflect balance among the ten ACA-required categories of benefits; (4) account for diverse health needs across many populations; (5) ensure that there are no incentives for coverage decisions, cost sharing, or

¹⁷⁵ *Id.*

¹⁷⁶ *Id.* at 10-11.

¹⁷⁷ *Id.* at 11-12.

¹⁷⁸ *Id.*

¹⁷⁹ EHB BULLETIN, *supra* note 23, at 3.

¹⁸⁰ *See id.* at 3.

¹⁸¹ *See id.*

¹⁸² *Id.*

¹⁸³ *Id.* at 1.

reimbursement rates to discriminate impermissibly against individuals because of their age, disability, or expected length of life; (6) ensure compliance with MHPAEA; (7) provide states a role in defining the EHB Package; and (8) balance comprehensiveness and affordability for those purchasing coverage.¹⁸⁴

Given the Committee's recommendations in its *Consensus Report*, including the Committee's recommendation that the Secretary's initial guidance should list standard benefit inclusions and exclusions at a level of specificity at least comparable to current best practice in the private and public insurance market, the content of the *EHB Bulletin* is surprising. In the *EHB Bulletin*, HHS explains its intent not to propose one comprehensive, specific benefit package for all health plans in the nation to follow.¹⁸⁵ Instead, HHS intends to leave the states broad discretion in defining the EHB Package by allowing each state to select a benchmark plan in that state.¹⁸⁶ The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a typical employer plan in that state.¹⁸⁷ According to statements made by the Secretary at a news conference, HHS's goal is to ensure that state leaders can tailor health insurance requirements to local conditions and priorities; that is, "[c]overage that works in Florida may not work in Nebraska."¹⁸⁸ HHS intends not only to allow health insurance issuers to adopt the scope of services and limits of the selected state benchmark, but also to vary the benchmarked benefits within certain parameters.¹⁸⁹

More specifically, HHS intends to propose that states select a single benchmark to serve as the standard for both exchange-offered qualified health plans in the state as well as non-exchange-offered individual and small group health plans in the state.¹⁹⁰ HHS believes that the following four benchmark plans, at least for the two-year (2014-2015) transition period immediately following the compliance date for the EHB Provision, best reflect ACA's intent: (1) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market; (2) any of the largest three state employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefit Program (FEHBP) plan options by enrollment; or (4) the largest insured commercial non-Medicaid HMO operating in the state.¹⁹¹ HHS intends to assess the benchmark process for year 2016 and beyond based on evaluation and feedback.¹⁹²

If a state does not exercise the option to select a benchmark health plan, HHS intends to propose that the default benchmark plan for the state will be the largest plan by enrollment in the largest product in the state's small group market.¹⁹³ In light of ACA's requirement that states defray the costs of state-mandated benefits in excess of the EHB Package for individuals enrolled in any qualified health plan

¹⁸⁴ *Id.* at 8.

¹⁸⁵ See Farley, *supra* note 26.

¹⁸⁶ EHB BULLETIN, *supra* note 23, at 8.

¹⁸⁷ *Id.*

¹⁸⁸ N.C. Aizenman, *States Will Have Flexibility in Defining Required Health Coverage*, WASH. POST, Dec. 17, 2011, at A5, available at http://www.washingtonpost.com/national/health-science/minimum-essential-health-benefits-will-be-largely-set-by-states/2011/12/16/gIQAx5FHZ0_story.html.

¹⁸⁹ EHB BULLETIN, *supra* note 23, at 8-9.

¹⁹⁰ *Id.* at 9.

¹⁹¹ *Id.*

¹⁹² *Id.*

¹⁹³ *Id.*

either in the individual market or in the small group market,¹⁹⁴ if a state chooses in transitional years 2014 and 2015 a benchmark such as the FEHBP plan that may not include some or all of the state's mandated benefits, the state would be required to cover the costs of those mandates outside the state EHB Package.¹⁹⁵ On the other hand, if a state chooses a benchmark subject to state mandates, such as a small group market plan, that benchmark would include those mandates in the state EHB Package.¹⁹⁶ HHS intends to evaluate the benchmark approach for calendar year 2016 and develop an approach that may exclude some state benefit mandates from inclusion in the state EHB Package.¹⁹⁷

HHS recognizes that not every state-selected benchmark plan will cover all ten categories of ACA-required services.¹⁹⁸ For example, some selected benchmark plans may not include habilitative services, pediatric oral and vision services, or mental health and substance use disorder services (especially in light of MHPA and MHPAEA, neither of which contains a mandatory mental health or substance use disorder benefit).¹⁹⁹ HHS intends to propose that if a selected benchmark is missing an ACA-required benefit category, the benefit category must nevertheless be covered by health plans required to offer the EHB Package.²⁰⁰ Stated another way, a state may need to supplement the benchmark plan to cover all ten of the ACA-required benefit categories.²⁰¹ HHS intends to propose that if a benchmark plan is missing one or more categories of required benefits, the state must supplement the missing categories using the benefits from any other benchmark option.²⁰² In a state with a default benchmark with missing categories, the benchmark plan would be supplemented using the largest plan in the benchmark type (e.g., small group plans or state employee plans of FEHBP) by enrollment offering the benefit.²⁰³ If none of the benchmark options in that benchmark type offer the benefit, the benefit will be supplemented using the FEHBP plan with the largest enrollment.²⁰⁴

HHS also intends to propose that mental health parity (i.e., MHPA as expanded by MHPAEA) applies in the context of health plans required to provide the EHB Package, consistent with ACA's statutory extension of federal mental health parity law to qualified health plans discussed in Part III.C, *supra*.²⁰⁵

HHS further intends to propose that health plan benefits be "substantially equal" to the benefits of the benchmark plan selected by the state and modified as necessary

¹⁹⁴ ACA, Pub. L. No. 111-148, § 1311(d)(3)(B)(ii), 124 Stat. 119, 173 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

¹⁹⁵ EHB BULLETIN, *supra* note 23, at 9.

¹⁹⁶ *Id.* at 9-10.

¹⁹⁷ *Id.* at 10.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.* For example, in a state where the default benchmark is in place but that default plan does not offer mental health and substance abuse disorder benefits, the benchmark would be supplemented using the mental health and substance use disorder benefits offered in the largest small group benchmark plan option with coverage for mental health and substance use disorder benefits. *Id.* If none of the three small group market benchmark options offer mental health and substance use disorder benefits, that category would be based on the largest plan offering mental health and substance use disorder benefits in FEHBP. *Id.*

²⁰⁵ *Id.* at 12.

to reflect the ten ACA-required service categories.²⁰⁶ More specifically, HHS intends to propose that insurers have some flexibility to adjust benefits, including both the specific services covered and any quantitative limits, provided that they continue to cover all ten of the ACA-required benefit categories.²⁰⁷ According to HHS, permitting some flexibility will: (1) provide greater choice to consumers; (2) promote plan innovation through coverage and design options; and (3) ensure that plans providing the EHB Package offer a certain minimum level of benefits.²⁰⁸ HHS also intends to consider permitting benefit substitutions within and across each of the ten ACA-required benefit categories.²⁰⁹

Again, HHS's purpose in issuing the *EHB Bulletin* is to provide information regarding its current intentions with respect to regulations it plans to propose in the future.²¹⁰ The *EHB Bulletin* is not, then, a formal set of proposed regulations designed to satisfy the Federal Administrative Procedure Act's notice and comment rule-making process. Like proposed rules, however, HHS is welcoming public input regarding the *EHB Bulletin* and received comments through January 31, 2012.²¹¹ As of this writing, HHS has yet to issue proposed or final regulations implementing the EHB Provision.

Following January 1, 2014, the compliance deadline for the EHB Provision, HHS estimates that 4.8 million Americans who purchase health insurance in the individual market will gain some substance abuse coverage at parity with medical and surgical benefits and that 2.3 million Americans who purchase health insurance in the same market will gain some mental health coverage at parity with medical and surgical benefits.²¹² However, the extent to which specific mental health and substance use disorder benefits ultimately are required to be provided to a specific insured depends on whether HHS adopts its intended approach described in the *EHB Bulletin* in final regulations and, if so, the benchmark plan that is actually selected by (or defaulted to in) each state,²¹³ the extent to which insurers are permitted to adjust the benchmark benefits, and the extent to which HHS allows service substitutions within and across the ten ACA-required benefit categories.²¹⁴ If a state selects (or is defaulted to) a benchmark plan with modest mental health and substance use disorder benefits, many individuals with mental illness, including alcohol and drug addiction, may not have a federal legal right to insurance benefits that will cover all of the inpatient and outpatient services that are recommended for

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ *See id.* at 1.

²¹¹ *Id.*

²¹² ASPE ISSUE BRIEF, *supra* note 136, at 1. These numbers do not include estimates of the non-individual (or small group) market enrollees whose coverage does not currently include mental health and substance use disorder benefits. *Id.* at 2 n.4.

²¹³ *See, e.g.*, CONSENSUS REPORT, *supra* note 17, at 62 (discussing variation among insurers with respect to certain categories of benefits, including mental health and substance use disorder benefits; noting that some services such as inpatient and outpatient substance abuse detoxification are less frequently covered); Kavita Patel, *Essential Health Benefits: Policy Considerations*, HEALTH AFF. BLOG (Dec. 28, 2011, 2:51 PM), <http://healthaffairs.org/blog/2011/12/28/essential-health-benefits-policy-considerations/> (“[B]oth ASPE researchers as well [as] private sector surveys have found a great deal of variation around benefits in behavioral health . . .”).

²¹⁴ *See* EHB BULLETIN, *supra* note 23, at 12 (discussing HHS's intent to allow health plans to offer benefits that are “substantially equal” to the benchmark benefits and the fact that HHS is considering permitting substitutions within and across the ten ACA-required benefit categories).

their conditions.²¹⁵ On the other hand, if a state selects (or is defaulted to) a benchmark plan with comprehensive mental health and substance use disorder benefits, a greater number of individuals with mental illness in that state will have a federal legal right to insurance coverage of medically necessary evidence-based mental health treatments, unless HHS allows health plans in the state to substantially adjust away from the benchmarked mental health benefits or substitute benefits in one of the other nine ACA-required categories for the benchmarked mental health benefits.

IV. ANALYSIS AND PROPOSAL

This Part IV analyzes the initial steps taken by HHS to implement the EHB Provision,²¹⁶ with a focus on the potentially negative clinical implications for individuals with mental health and substance use disorders and the potentially negative cost implications for health plans. Thus far, HHS understandably has focused on the EHB Package as a whole with scant attention devoted to mental health and substance use disorder benefits. On page 5 of the *EHB Bulletin*, HHS briefly notes that not all plans and health insurance products cover mental health and substance use disorder services.²¹⁷ And, on page 12 of the *EHB Bulletin*, HHS briefly notes that mental health and substance use disorder services are part of the EHB Package and that ACA extends federal mental health parity law to the individual health plan setting and the exchange-offered qualified health plan setting.²¹⁸ Other than these two points, HHS has not focused on the particular issues surrounding mental health and substance use disorder benefits in publicly available documentation relating to its initial implementation of the EHB Package.

HHS's scant attention to mental health and substance use disorder benefits likely is due to the scant attention received by such benefits in the Committee's *Workshop Report* and *Consensus Report*. In the *Workshop Report*, the Committee explained that "time constraints prohibited the [C]ommittee from hearing testimony related to each of the[] [ten ACA-required] categories in detail."²¹⁹ Chapter 7 of the *Workshop Report* does highlight some testimony specifically relating to mental health and substance use disorder benefits, however.²²⁰ Dr. Kenneth Wells of the David Geffen School of Medicine at UCLA, Dr. Kavita Patel of the Semel Institute for Neuroscience and Human Behavior at UCLA, and Mr. Paul Samuels of the Legal Action Center and the Coalition for Whole Health provided important testimony regarding the need for access to a range of evidence-based mental health and substance use disorder treatments, the fact that mental health treatments must recognize the chronic (not just acute) dimensions of mental illness, and the need for collaboration and integration of services across the mental health, substance use disorder, and physical health sectors.²²¹ Individually, Dr. Wells also briefly addressed the association between mental illness and physical illness (including the fact that individuals with mental illness have a higher prevalence of physical illness),

²¹⁵ See, e.g., Farley, *supra* note 26.

²¹⁶ See ACA, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119, 163 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

²¹⁷ EHB BULLETIN, *supra* note 23, at 5-6.

²¹⁸ *Id.* at 12.

²¹⁹ WORKSHOP REPORT, *supra* note 10, at 71.

²²⁰ *Id.* at 71-82.

²²¹ *Id.* at 71-77.

the role of mental illness in premature mortality and morbidity, and the cost effectiveness of mental health treatments when viewed in light of societal costs associated with mental illness.²²² Dr. Patel also briefly addressed the importance of covering community-based mental healthcare, including the services provided by lay community workers and social caseworkers, citing the efficacy of community-based mental healthcare as reported in the National Institute of Mental Health's *Community Partners in Care* study, which focused on the quality of mental healthcare provided to individuals with depression in Los Angeles²²³ as well as the Mental Health Infrastructure and Training Project, which focused on the mental healthcare needs of individuals with depression and post-traumatic stress disorder in post-Katrina New Orleans.²²⁴ Finally, Mr. Samuels briefly addressed the importance of treating mental illness in light of co-morbidity problems.²²⁵ Mr. Samuels explained that twenty-five percent of hospital admissions are directly related to untreated mental illness and substance use disorders, and the failure of insurers to adequately cover mental illness "cost[s] a lot of money" because individuals with untreated mental illness frequently develop physical illnesses (including heart disease and liver failure) when their underlying mental illnesses are not addressed.²²⁶ Mr. Samuels concluded by stating that, "[a]ddressing these unmet [mental health] needs 'will save lives and huge amounts of money.'"²²⁷ Other than presenting these three brief pieces of testimony, the *Workshop Report* did not specifically focus on mental health and substance use disorder benefits.

The *Consensus Report* also focused little on mental health and substance use disorder benefits other than recognizing that not all health plans cover substance abuse detoxification services,²²⁸ that mental health and substance abuse coverage in individual health plans has varied more than in small group health plans, with coverage criteria being more influenced by state mandates,²²⁹ that mental health and substance use disorder services appear less likely to be covered in standard commercial subscriber contracts,²³⁰ and that, in terms of defining the EHB Package, areas of particular complexity include mental health services.²³¹

This Part IV seeks to remedy the informational and research limitations in HHS's initial steps towards implementing the EHB Package. Perhaps the primary theme of the *Workshop Report*, the *Consensus Report*, and the *EHB Bulletin* with respect to all ten of the ACA-required benefit categories was the perceived tension between developing a comprehensive EHB Package and keeping healthcare costs down.²³² The *Workshop Report* presented many pieces of testimony that addressed

²²² *Id.* at 72-73.

²²³ *Id.* at 74 (citing Bowen Chung et al., *Using a Community Partnered Participatory Research Approach to Implement a Randomized Controlled Trial: Planning Community Partners in Care*, 21 J. HEALTH CARE FOR POOR & UNDERSERVED 780, 780-95 (2010)).

²²⁴ *Id.* (citing Ashley Wennerstrom et al., *Community-Based Participatory Development of a Community Health Worker Mental Health Outreach Role to Extend Collaborative Care in Post-Katrina New Orleans*, 21 ETHNICITY & DISEASE S1-45, S1-45 – S1-51 (2011); Benjamin F. Springgate et al., *Mental Health Infrastructure and Training Project*, 21 ETHNICITY & DISEASE S1-20 (2011)).

²²⁵ *Id.* at 76.

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ CONSENSUS REPORT, *supra* note 17, at 62.

²²⁹ *Id.* at 72.

²³⁰ *Id.* at 81.

²³¹ *Id.* at 125.

²³² See *infra* text accompanying notes 239-42.

the “clear tension between the desire to make the EHB [P]ackage as comprehensive as possible and the need to make the EHB [P]ackage affordable”²³³ Dr. Louis Jacques, Director of the Coverage & Analysis Group at the Centers for Medicare & Medicaid Services, specifically addressed the “competing needs of generosity and affordability.”²³⁴ The *Consensus Report* also focused on comprehensiveness of benefits versus cost: “If the package of benefits is too narrow, health insurance might be meaningless; if it is too broad, insurance might become too expensive.”²³⁵ The *EHB Bulletin* also stated as one of HHS’s main goals “balancing comprehensiveness and affordability.”²³⁶

Part IV argues that the intense focus on the perceived relationship between the comprehensiveness of benefits and healthcare costs in the *Workshop Report*, *Consensus Report*, and *EHB Bulletin* might be misplaced in the context of mental health and substance use disorder benefits. More specifically, this Part IV urges HHS to consider the current empirical literature suggesting that, holding other non-mental health and substance use disorder benefits equal, the availability and use of medically necessary mental health and substance use disorder benefits by individuals with mental illnesses may actually lower the total (that is, the combined physical and mental) healthcare costs for those individuals, thus making the provision of comprehensive inpatient, outpatient, and other mental health and substance use disorder benefits by health plans an economically efficient long-term decision.²³⁷ Stated another way, this Part IV urges HHS to consider the possibility of long-term total healthcare cost returns on initial mental health treatment investments as HHS implements the Mental Health Benefit Sub-Provision.

A. TRADITIONAL CONCERNS REGARDING THE RELATIONSHIP BETWEEN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND HEALTHCARE COSTS²³⁸

The belief that mandatory mental health and substance use disorder benefits and mental health parity will cause healthcare costs to rise is not new.²³⁹ As background,

²³³ WORKSHOP REPORT, *supra* note 10, at 3.

²³⁴ *Id.*

²³⁵ CONSENSUS REPORT, *supra* note 17, at xi.

²³⁶ EHB BULLETIN, *supra* note 23, at 8.

²³⁷ *See infra* Part IV.B.

²³⁸ Parts IV.A-B of this Article are reprinted with updates and minor changes with permission from Tovino, *supra* note 2, at pt. III.B. Part IV.C of this Article is new.

²³⁹ *See, e.g., Parity of Medicare Benefits for Persons with Mental and Substance Use Conditions: Before the H. Subcomm. on Health of the H. Comm. on Ways and Means*, 110th Cong. 2 (2007) (statement of Eric Goplerud, Ph.D., Research Professor, Dep’t of Health Policy, George Washington Univ. Med. Ctr.) [hereinafter Goplerud Statement] (“There was a concern (perhaps justifiable) that equitable coverage would lead to overuse and uncontrolled costs.”); SURGEON GENERAL REPORT, *supra* note 37, at 418 (“[Private i]nsurers feared that coverage of mental health services would result in high costs associated with long-term and intensive psychotherapy and extended hospital stays These factors encouraged private insurers to limit coverage for mental health services.”); Barry, *Political Evolution*, *supra* note 37, at 186–87 (identifying a general perception among policymakers in the late 1970s and the early 1980s that “broad coverage for mental health was expensive and unpredictable”); *id.* at 189 (“Cost has always been a salient feature of the political debate over benefit regulation.”); Allan Beigel & Steven S. Sharfstein, *Mental Health Care Providers: Not the Only Cause or Only Cure for Rising Costs*, 141 AM. J. PSYCHIATRY 668, 668 (1984) (“During the past 25 years . . . [c]osts have risen, resulting in resistance to financing treatment of mental illness on both the public and private sectors.”); Richard G. Frank et al., *Will Parity in Coverage Result in Better Mental Health Care?*, 345 NEW ENG. J. MED. 1701, 1701 (2001) (“Potential costs are one reason insurers treat mental health services differently.”); Kaplan, *supra* note 59, at 337 (“Opponents of mental health

health insurers historically have focused on the problems of moral hazard and adverse selection when justifying mental health benefit disparities.²⁴⁰ In the context of mental healthcare, moral hazard refers to the concern that individuals who do not pay for 100% of the cost of their own mental healthcare will use more mental health services because they do not value these services at their full cost.²⁴¹ To control moral hazard in the context of mental healthcare, insurers traditionally have imposed lower inpatient day and outpatient visit maximums, as well as higher deductibles, co-payments, and co-insurance amounts, on mental healthcare.²⁴² Notwithstanding insurers' concerns regarding moral hazard in the context of mental healthcare, many of which may be linked to the three-decades-old RAND Health Insurance Experiment,²⁴³ recent studies demonstrate that the demand for mental health services is less price elastic than the demand for physical health services and that the current demand for mental health services is less price elastic than the demand for mental health services was twenty-five to thirty years ago.²⁴⁴ Recent studies also suggest

parity . . . cite studies and reports that demonstrate that mental health parity will result in a significant increase in the cost of employee insurance coverage.”); Nelson, *supra* note 68, at 106.

²⁴⁰ 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, 5424 (Feb. 2, 2010) (“A frequent justification for higher cost-sharing of mental health and substance use disorder benefits is the greater extent of moral hazard for these benefits; individuals will utilize more mental health and substance use disorder benefits at a higher rate when they are not personally required to pay the cost.”); SURGEON GENERAL REPORT, *supra* note 37, at 420 (discussing the concepts of moral hazard and adverse selection in the context of mental health insurance); Frank et al., *supra* note 239, at 1701-02.

²⁴¹ See, e.g., SURGEON GENERAL REPORT, *supra* note 37, at 420 (discussing the concept of moral hazard in the context of mental healthcare); see also Richard G. Frank & Thomas G. McGuire, *Parity for Mental Health and Substance Abuse Care under Managed Care*, 1 J. MENTAL HEALTH POL’Y & ECON. 153, 155 (1998) [hereinafter Frank & McGuire, *Parity*].

²⁴² See SURGEON GENERAL REPORT, *supra* note 37, at 420; see also Barry et al., *Still Unequal*, *supra* note 57, at 130 (“Health plans have historically attempted to control costs by requiring that enrollees pay more at the point of service for mental health care compared with other medical services.”).

²⁴³ In 1971, the former Federal Department of Health, Education, and Welfare began funding the RAND Health Insurance Experiment (HIE), a multi-year, multi-million dollar experimental study of healthcare costs, utilization, and outcomes. The HIE, frequently referred to as the largest health policy study in U.S. history, reported that patient cost-sharing reduces “inappropriate” or “unnecessary” medical care as well as “appropriate or needed” medical care. See DEP’T HEALTH, EDUC. & WELFARE, RAND HEALTH INSURANCE EXPERIMENT (1982); RAND CORP., THE HEALTH INSURANCE EXPERIMENT: A CLASSIC RAND STUDY SPEAKS TO THE CURRENT HEALTH CARE REFORM DEBATE (2006) (summarizing the HIE’s principal questions and findings). The study’s applicability to today’s managed care-dominated healthcare delivery market has recently been challenged: “[M]any have cited the RAND Health Insurance Experiment . . . which demonstrated that individuals are more likely to increase their mental health care usage when their personal cost-sharing for mental health care services fall than they are to increase their physical health care usage when their personal cost-sharing for physical health care services decreases. Because this experiment was conducted nearly thirty years ago, researchers recently tested to determine whether this result held true. Their results indicate that individuals’ sensitivity to changes in cost-sharing may have changed significantly over time.” Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. at 5424.

²⁴⁴ See, e.g., Chad D. Meyerhoefer & Samuel H. Zuvekas, *New Estimates of the Demand for Physical and Mental Health Treatment*, 19 J. HEALTH ECON. 297, 297 (2010) (“Results from our correlated random effects specification indicate that the price responsiveness of ambulatory mental health treatment has decreased substantially and is now slightly lower than physical health treatment This suggests that concerns over moral hazard alone do not warrant less generous coverage for mental health.”).

that deductibles (in both the traditional indemnity²⁴⁵ and managed care²⁴⁶ settings) and co-insurance amounts (in the managed care setting) have no impact and very little impact, respectively, on the demand for mental healthcare.²⁴⁷ Additional studies that analyze the impact of managed healthcare and behavioral health carve-out plans²⁴⁸ on demand for mental healthcare suggest that the implementation of managed behavioral healthcare undermines the assumed demand response as an efficiency argument against parity.²⁴⁹ As a result, economists now suggest that the imposition of higher deductibles, co-payments, and co-insurance amounts on mental healthcare may no longer be justified on efficiency grounds and that the traditional practice of unequal health insurance benefit sets may need to be revisited.²⁵⁰

Traditionally, insurers also have been concerned with adverse selection; that is, the concern that in a healthcare market with voluntary insurance or multiple insurers, plans that offer generous mental health benefits will attract individuals with greater mental healthcare needs, leading to higher service usage and costs for those insurers.²⁵¹ Historically, many insurers have not offered mental health benefits as a way of controlling adverse selection.²⁵² Of course, the two pre-conditions to adverse selection (voluntary insurance and multiple insurers) have been at the heart of the

²⁴⁵ In a traditional indemnity health plan, patients are free to select their primary care providers, specialty care providers, and hospital and other institutional care providers. However, indemnity plan patients usually are subject to relatively high deductibles and co-insurance amounts. *See How do Deductibles and Copays Work?*, STAY SMART STAY HEALTHY, http://www.staysmartstayhealthy.com/deductibles_and_copays (last visited Mar. 3, 2012).

²⁴⁶ In a managed care plan, enrollees usually are assigned to a primary care provider who must pre-authorize access to a specialty healthcare provider. Managed care plan enrollees typically pay a small co-payment (e.g., ten, fifteen, or twenty-five dollars) for each visit to a primary care or specialty care provider instead of a high deductible combined with co-insurance. Coverage is usually limited to a small class of providers in a particular service area, unless the enrollee has an emergency medical condition. In the typical managed care plan, healthcare is rationed and healthcare costs are controlled by managers, not by high cost-sharing amounts imposed on enrollees. *See, e.g.*, Leonard S. Goldstein, *Genuine Managed Care in Psychiatry: A Proposed Practice Model*, 11 GEN. HOSP. PSYCHIATRY 271, 271 (1989) (referencing several definitions of managed care; offering one definition of “genuine managed care[;]” that is, the attempt to improve, where possible, the system of care; and characterizing other definitions of managed care by their attempts to lower the cost of medical care through benefit barriers, access barriers, treatment restrictions, case management, and other interventions).

²⁴⁷ *See, e.g.*, Chunling Lu et al., *Demand Response of Mental Health Services to Cost Sharing Under Managed Care*, 11 J. MENTAL HEALTH POL’Y & ECON. 113 (2008) [hereinafter Lu et al., *Demand Response*].

²⁴⁸ *See infra* notes 334-36 and accompanying text for a discussion of behavioral health carve-out plans.

²⁴⁹ *See, e.g.*, Frank & McGuire, *Parity*, *supra* note 241, at 153 (“Because costs are controlled by management under managed care and not primarily by out of pocket prices paid by consumers, demand response recedes as an efficiency argument against parity.”); Ching-to Albert Ma & Thomas C. McGuire, *Costs and Incentives in a Behavioral Health Carve-Out*, 17 HEALTH AFF. 53, 56-64 (1998) (reporting studies in Massachusetts Medicaid and other contexts showing an association between behavioral health carve-outs and significant savings (e.g., twenty-five to sixty percent) per enrollee due to the virtual elimination of inpatient treatment).

²⁵⁰ *See* Meyerhoefer & Zuvekas, *supra* note 244, at 312.

²⁵¹ *See, e.g.*, SURGEON GENERAL REPORT, *supra* note 37, at 420 (discussing adverse selection in the context of mental healthcare); Frank & McGuire, *Parity*, *supra* note 241, at 156.

²⁵² SURGEON GENERAL REPORT, *supra* note 37, at 420; *see also* Barry et al., *Still Unequal*, *supra* note 57, at 134 (discussing adverse selection in the context of mental healthcare; explaining that “adverse-selection incentives could play a role in explaining the endurance of benefit limits. While the advent of managed care has attenuated fears that coverage expansions would exacerbate cost control problems, benefit restrictions could be motivated by a health plan’s desire to avoid enrollees with a propensity to avail themselves of mental health care.”).

U.S. healthcare reform debate.²⁵³ Although Congress elected not to proceed with a single-payer system, ACA requires most individuals to maintain minimum essential health insurance coverage²⁵⁴ and requires exchange-offered qualified health plans, non-exchange-offered individual health plans, non-exchange-offered small health plans, Medicaid benchmark and benchmark-equivalent plans, and state basic healthcare plans to include the EHB Package in certain health plan settings, including mental health and substance use disorder benefits.²⁵⁵ If upheld,²⁵⁶ these two sets of ACA provisions will lessen insurers' risks relating to adverse selection beginning on the provisions' compliance date of January 1, 2014.²⁵⁷

B. EMPIRICAL LITERATURE ADDRESSING THE RELATIONSHIP BETWEEN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND HEALTHCARE COSTS

Perceived moral hazard and adverse selection concerns may continue to exist following January 1, 2014, however, because ACA does not currently require certain categories of health plans (including grandfathered health plans, large group health plans, and self-insured group health plans) to provide the EHB Package, including mental health and substance use disorder benefits.²⁵⁸ This Article is based on concern that such exempted health insurers—as well as those health plans that have significant leeway in designing their benefit packages and substituting essential services within and across ACA-required benefit categories—will continue to impose mental health benefit limitations and will provide minimal mental health and substance use disorder benefits, respectively, without recognizing the negative clinical and related cost implications of their benefit limitations and without taking into account the role of managed care in minimizing moral hazard and other efficiency concerns.²⁵⁹ To address these concerns, the current empirical literature regarding the relationship between mental health and substance use disorder benefits

²⁵³ See, e.g., David Brooks & Gail Collins, *What's Wrong with a Single-Payer System?*, N.Y. TIMES OPINIONATOR (July 29, 2009, 4:29 PM), <http://opinionator.blogs.nytimes.com/2009/07/29/whats-wrong-with-a-single-payer-system/>; Karen Davenport et al., *Should Health Insurance Be Mandatory?*, N.Y. TIMES ROOM FOR DEBATE (June 4, 2009, 7:43 PM), <http://roomfordebate.blogs.nytimes.com/2009/06/04/should-health-insurance-be-mandatory/> (five-author debate examining the merits of mandatory health insurance).

²⁵⁴ See ACA, Pub. L. No. 111-148, § 1501(a), 124 Stat. 119, 242-44 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (“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.”).

²⁵⁵ See *supra* Part III.C.

²⁵⁶ See *supra* note 106.

²⁵⁷ See, e.g., Frank et al., *supra* note 239, at 1702 (“Parity can improve the efficiency of insurance markets by eliminating wasteful forms of competition that are the result of adverse selection. Mandating a particular level of mental health care establishes a floor for coverage.”).

²⁵⁸ See *supra* Part III.C.; see also BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41069, SELF-INSURED HEALTH INSURANCE COVERAGE 5 (2010) (“[G]roup health plan or health insurance coverage . . . in which a person was enrolled on the date of enactment [of PPACA] is grandfathered and exempt from most insurance reforms.”).

²⁵⁹ See, e.g., Goplerud Statement, *supra* note 239, at 9 (discussing several economic, social, and other implications of untreated mental illness); Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5423-24 (Feb. 2, 2010) (discussing several economic implications of mental health benefit restrictions and recognizing that the moral hazard problem can be controlled through managed behavioral healthcare); SURGEON GENERAL REPORT, *supra* note 37, at 420 (discussing the clinical implications of mental health benefit restrictions).

and healthcare costs is presented below. As discussed in more detail below, a number of studies suggest that mental health benefit limitations may be associated with a lack of access to mental healthcare and untreated mental illness.²⁶⁰ Studies also suggest that untreated mental illness may increase total healthcare costs over and above the cost of treating the mental illness, perhaps because individuals who have a mental illness are more likely to have a physical illness²⁶¹ and because untreated mental illness can worsen the prognosis of, prolong the period of recovery from, and increase the risk of mortality associated with physical illness.²⁶² Finally, a number of studies suggest that treating mental illness may either decrease or not statistically significantly increase total healthcare costs, even taking into account the costs of the provided mental health treatment.²⁶³

In the early 1990s, researchers affiliated with the Group Health Cooperative of Puget Sound (“GHC”) desired to better understand the burden of depression on individual patients and society as a whole.²⁶⁴ As background, the researchers believed that diagnosis and treatment of depression in individuals could yield a societal return on investment by lowering rates of unemployment and disability, but the researchers were also aware of the need to understand and control healthcare costs as part of any policy recommendation or initiative.²⁶⁵ The researchers thus set out to investigate the relationship between untreated depression and total healthcare costs in 6257 GHC health maintenance organization (HMO) members who were eighteen years of age or older and were diagnosed with depression made during an outpatient visit between April 1, 1992, and December 31, 1992.²⁶⁶ Using computerized visit-diagnosis data, pharmacy records, and cost-accounting data from GHC, the researchers compared overall healthcare costs for primary care patients with recognized depression and overall healthcare costs for age- and gender-matched patients without depression.²⁶⁷ The researchers found that the patients diagnosed with depression had higher annual healthcare costs (\$4246 versus \$2371), and fifty to seventy-five percent higher costs for every category of care, including the primary care setting, all medical specialties, the medical inpatient setting, and the pharmacy

²⁶⁰ See, e.g., David R. McKusick et al., *Trends in Mental Health Insurance Benefits and Out-of-Pocket Spending*, 5 J. MENTAL HEALTH POL’Y ECON. 71, 71 (2002) (“Insurance benefits can have a large effect on whether one is able to access health care services When insurance covers more limited expenditures, more must be paid out-of-pocket by the insured and there is less incentive to use services and more financial risk.”).

²⁶¹ 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. at 5423-24 (“Mental health and physical health are interrelated, and individuals with poor mental health are more likely to have physical health problems as well.”).

²⁶² See, e.g., *id.* at 5424 (“[T]here is evidence that comorbid depression worsens the prognosis, prolongs recovery and may increase the risk of mortality associated with physical illness.”); RACHEL SETHI ET AL., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEP’T HEALTH & HUMAN SERVS., Pub. No. SMA-06-4177, DESIGNING EMPLOYER-SPONSORED MENTAL HEALTH BENEFITS 14 (2006) (reporting that depression following surgery for myocardial infarction is common but if left untreated can nearly double the risk of death eighteen months after heart surgery).

²⁶³ See Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. at 5424 (“Increased access and utilization of mental health and substance use disorder benefits could result in a reduction of medical/surgical costs for individuals afflicted with mental health conditions and substance use disorders.”).

²⁶⁴ See Gregory E. Simon et al., *Health Care Costs of Primary Care Patients with Recognized Depression*, 52 ARCHIVES GEN. PSYCHIATRY 850, 850 (1995).

²⁶⁵ See *id.*

²⁶⁶ *Id.* at 851.

²⁶⁷ *Id.* at 852.

and laboratory settings.²⁶⁸ The researchers concluded not only that the diagnosis of depression was associated with a twofold increase in use of health services²⁶⁹ but also that the greater medical utilization exceeded the costs that would be associated with treating the depression.²⁷⁰ As part of their conclusion, the researchers recommended that policy decisions regarding the scope of mental health benefits take into account the association between depression and total healthcare costs.²⁷¹

In 1997, researchers affiliated with GHC published the results of a second study designed “to examine whether depressive symptoms in older adults contribute to the increased cost of general medical services.”²⁷² The researchers conducted a four-year (1989-1993) prospective study of 2558 older-than-sixty-five adults in GHC.²⁷³ Through a mail survey and telephone interviews, the researchers measured each participant’s depressive symptoms at baseline (1989), at two years (1991), and at four years (1993).²⁷⁴ The researchers then compared each patient’s depressive symptoms to data obtained from GHC’s cost accounting system relating to each patient’s total healthcare costs.²⁷⁵ The researchers found that in the cohort of older adults studied, depressive symptoms were common, persistent, and associated with a significant increase in the cost of general medical services.²⁷⁶ More specifically, the researchers found that patients with significant depression at baseline had higher median costs (\$2147) during the first year after baseline than patients without depression (\$1461).²⁷⁷ Patients with significant depressive symptoms at baseline also had higher median costs at year four (\$15,423) than patients without depressive symptoms (\$10,152).²⁷⁸ The researchers also found that the increase in the cost of general medical services associated with depression was spread over all components of healthcare.²⁷⁹ During the year following baseline, for example, patients with depression had a higher number of inpatient admissions, outpatient visits, laboratory tests, emergency department visits, prescriptions, ancillary visits, and optometry visits.²⁸⁰ The researchers further found that the increase in the cost of general medical services was not accounted for by an increase in specialty mental healthcare,²⁸¹ and that even after adjusting for differences in age, sex, and severity of

²⁶⁸ *Id.* at 850-52.

²⁶⁹ *Id.* at 854 (“These data demonstrate markedly higher health care costs among HMO patients with recognized depression A twofold difference in total cost between those diagnosed as having depression and the comparison group was maintained over 12 months of observation, suggesting a chronic component to utilization differences.”).

²⁷⁰ *Id.* at 855 (“In this 9-month sample of HMO primary patients with recognized depression, depression-related specialty mental health care and antidepressant drugs accounted for approximately \$3.8 million, while greater use of general medical services accounted for \$8.9 million over 1 year.”). *See generally* Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5424 (Feb. 2, 2010) (explaining, for example, that “comorbid depression has been shown to increase the costs of medical care, over and above the costs of treating the depression itself.”).

²⁷¹ Simon et al., *supra* note 264, at 855.

²⁷² Jürgen Unützer et al., *Depressive Symptoms and the Cost of Health Services in HMO Patients Aged 65 Years and Older*, 277 JAMA 1618, 1618 (1997).

²⁷³ *Id.* at 1618-19.

²⁷⁴ *Id.* at 1619.

²⁷⁵ *Id.*

²⁷⁶ *Id.* at 1618.

²⁷⁷ *Id.* at 1620.

²⁷⁸ *Id.*

²⁷⁹ *Id.* at 1618, 1621.

²⁸⁰ *Id.* at 1620.

²⁸¹ *Id.* at 1618, 1621.

chronic medical illness, the increase in healthcare costs remained significant.²⁸² The researchers formally concluded that depressive symptoms in older adults are associated with a significant increase—roughly fifty percent—in the total cost of general medical services.²⁸³ The researchers also suggested that mental health insurance benefit disparities might be short-sighted because they ultimately may increase total healthcare costs.²⁸⁴

Similar findings have been shown in other healthcare delivery settings. In 2009, researchers affiliated with Massachusetts General Hospital and Massachusetts Institution of Technology published the results of a study designed to better understand the interaction between depression and the cost of non-mental healthcare in eleven chronic co-morbid diseases.²⁸⁵ To that end, the researchers examined the insurance claims of 618,780 patients enrolled in self-insured, private healthcare plans based primarily in Texas, California, and across the eastern seaboard.²⁸⁶ The researchers examined the insurance records, dating from September 1, 2004, to August 31, 2005, for total annual non-mental health costs in eleven different disease categories, including asthma, back pain, congestive heart failure, coronary artery disease, diabetes, epilepsy, headache, hypertension, intervertebral disc disease, obesity, and joint pain.²⁸⁷ In each disease cohort, the researchers calculated median annual non-mental health cost for individuals with and without depression.²⁸⁸ The researchers found that patients with depression had higher median per-patient annual non-mental health costs than patients without depression in all eleven diseases studied.²⁸⁹ The per-patient difference in non-mental health costs between non-depressed and depressed patients ranged from \$1570 in obesity to \$15,240 in congestive heart failure.²⁹⁰ The ratio of cost between non-depressed and depressed patients ranged from 1.5 in obesity to 2.9 in epilepsy.²⁹¹ The researchers also found that the median annual pharmaceutical costs for the depressed patients were consistently higher than the pharmaceutical costs for the non-depressed patients, with a difference ranging from \$590 in obesity to \$1410 in epilepsy.²⁹² Finally, the researchers found that “each of the 11 chronic co-morbid diseases was more prevalent in the depressed cohort than in the non-depressed cohort” (with the ratio of

²⁸² *Id.* at 1618, 1620-21.

²⁸³ *Id.* at 1618, 1621.

²⁸⁴ *Id.* at 1622 (“Our findings on the costs of health services are important because by the year 2040, persons older than 65 years are projected to make up 21% of the population and consume almost half of the nation’s health care resources. Medicare currently spends only about 3% of its resources on mental health care and continues to have a 50% [now 45%] copayment for most outpatient mental health services. These policies may shift the costs of mental health treatment to primary care, where the lack of recognition and adequate treatment of depression are well documented and where depression may manifest itself in higher general medical costs. If depression is indeed a significant contributor to total health care costs, such restrictions of access to mental health services may be shortsighted.”(footnotes omitted)).

²⁸⁵ See Charles A. Welch et al., *Depression and Costs of Health Care*, 50 *PSYCHOSOMATICS* 392, 392 (2009).

²⁸⁶ *Id.* at 393.

²⁸⁷ *Id.*

²⁸⁸ *Id.* at 394.

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ *Id.*

²⁹² *Id.* at 394-95.

prevalence between non-depressed and depressed patients ranging from 1.4 in coronary artery disease and hypertension to 6.8 in obesity).²⁹³

Given this data, the Massachusetts-based researchers formally concluded that, even when controlling for the number of chronic co-morbid diseases, depressed patients had significantly higher costs than non-depressed patients in a magnitude consistent across the eleven chronic co-morbid diseases.²⁹⁴ The researchers suggested several potential reasons for their findings, including the possibility that depressed patients engage in self-neglect, including non-compliance with recommended healthcare.²⁹⁵ By way of explanation, the researchers noted that other studies have shown that self-neglect in diabetes and heart disease patients is correlated with higher utilization of emergency room, outpatient, inpatient, and specialty services.²⁹⁶ The researchers also identified as a possible cause the association between depression and “higher rates of harmful lifestyle factors such as smoking, overeating, and lack of physical activity,” as well as more severe pathophysiology across all chronic disease categories.²⁹⁷ Finally, the researchers raised the question, but were unable to answer, whether there may be metabolic factors associated with depression that exacerbate the pathophysiology of co-morbid diseases.²⁹⁸

Similar depression-to-cost findings also have been demonstrated in the public healthcare program setting. In 2009, researchers at the University of Washington, Columbia University, the National Institute of Mental Health, and Green Ribbon Health published their analysis of the healthcare claims of 14,902 Medicare beneficiaries who were enrolled in a pilot disease management program designed to investigate the association between depression and total healthcare costs as well as specific components of healthcare costs.²⁹⁹ The majority of the Medicare beneficiaries studied had diabetes, many had congestive heart failure, and approximately twenty percent had both diabetes and congestive heart failure.³⁰⁰ The researchers divided the beneficiaries into three mental health status groups: 2108 beneficiaries who had been diagnosed with depression, 1081 beneficiaries who had not been officially diagnosed with depression but who screened positive when given a questionnaire or who reported taking antidepressant medication, and 11,713 beneficiaries who did not have depression.³⁰¹ The researchers found that the beneficiaries diagnosed with depression incurred approximately \$22,960 in total

²⁹³ *Id.* at 395.

²⁹⁴ *Id.* Other studies report similar findings. See, e.g., Bruce A. Arnow et al., *Relationships Among Depression, Chronic Pain, Chronic Disabling Pain, and Medical Costs*, 60 PSYCHIATRIC SERVS. 344, 344 (2009) (finding that patients with major depressive disorder and co-morbid disabling chronic pain had higher medical service costs than other groups of patients who had either disabling chronic pain or depression or neither); Leonard E. Egede, Deyi Zheng & Kit Simpson, *Comorbid Depression Is Associated with Increased Health Care Use and Expenditures in Individuals with Diabetes*, 25 DIABETES CARE 464, 464 (2002) (finding that “depression in individuals with diabetes is associated with increased health care use and expenditures, even after adjusting for differences in age, sex, race, ethnicity, health insurance, and comorbidity”).

²⁹⁵ Welch et al., *supra* note 285, at 399.

²⁹⁶ *Id.*

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ Jürgen Unützer et al., *Healthcare Costs Associated with Depression in Medically Ill Fee-for-Service Medicare Participants*, 57 J. AM. GERIATRIC SOC. 506 (2009) [hereinafter Unützer et al., *Healthcare Costs*].

³⁰⁰ *Id.* at 507.

³⁰¹ *Id.* at 508.

healthcare costs over one year, while those without depression incurred costs of approximately \$11,956 over the same year.³⁰² Medicare beneficiaries with possible depression based on depression screening or reported antidepressant use incurred \$14,365 in total annual healthcare costs.³⁰³

The researchers found that the beneficiaries with diagnosed depression spent significantly more in almost all healthcare cost categories, including home healthcare, skilled nursing care, outpatient non-mental healthcare, inpatient non-mental healthcare, physician services, and durable medical equipment.³⁰⁴ The beneficiaries with diagnosed depression did not, however, spend more money on specialty mental healthcare compared to the beneficiaries without depression.³⁰⁵ Total mental healthcare costs accounted for less than two percent of total healthcare costs for the beneficiaries with depression.³⁰⁶ The researchers formally concluded that among the Medicare beneficiaries with chronic medical illness whose data was used in the study, those who also had depression both had significantly higher healthcare costs and were not receiving enough mental healthcare.³⁰⁷ The researchers theorized that the higher Medicare co-payments that applied to outpatient mental healthcare (fifty percent at the time of the study, now forty percent) compared to outpatient physical healthcare (twenty percent then and now) posed an obstacle to the receipt of needed mental healthcare.³⁰⁸ The researchers suggested in their conclusion that evidence-based depression care may yield long-term cost savings.³⁰⁹

Given the literature showing an association between untreated mental illness and healthcare cost increases, a number of research groups began to investigate whether treatment of mental illness could produce subsequent decreases in total healthcare costs. To that end, researchers affiliated with GHC published in 2006 the results of a study investigating the association between depression treatment and healthcare costs over the subsequent six months.³¹⁰ In their research, the study authors analyzed data obtained from GHC associated with 1814 patients who met the criteria for major depressive episode and entered treatment.³¹¹ Thirty-four percent of the patients whose data were analyzed achieved remission from depression, thirty-seven percent improved but did not meet criteria for remission, and twenty-nine percent had persistent major depression three to four months later.³¹² After adjusting for baseline differences in the severity of each patient's initial depression and expected healthcare costs, the study authors found that mean health services costs over the six months following acute-phase treatment were \$2012 for those achieving remission, \$2571 for those improved but not remitted, and \$3094 for those with

³⁰² *Id.*

³⁰³ *Id.*

³⁰⁴ *Id.* at 509.

³⁰⁵ *Id.*

³⁰⁶ *Id.* at 508.

³⁰⁷ *Id.* at 509.

³⁰⁸ *Id.* at 510.

³⁰⁹ *Id.*

³¹⁰ Gregory E. Simon et al., *Recovery from Depression Predicts Lower Health Services Costs*, 67 J. CLINICAL PSYCHIATRY 1226 (2006).

³¹¹ *Id.* at 1226, 1228-29. The patient data analyzed was representative of GHC's general patient population, including private employer-enrolled members, Medicare beneficiaries, Medicaid beneficiaries, and enrollees of the Washington Basic Health Plan, a state-subsidized program for low-income residents of the State of Washington. *Id.* at 1227.

³¹² *Id.* at 1226, 1228.

persistent major depression.³¹³ The study authors also found that average costs for depression treatment, including antidepressant prescriptions, outpatient visits, and mental health inpatient care, ranged from \$429 in the full remission group to \$585 in the persistent depression group.³¹⁴ The authors formally concluded that remission from depression is associated with significantly lower subsequent healthcare services utilization and healthcare costs across the full range of mental health and general medical services compared with persistent depression.³¹⁵

Similar findings have been demonstrated in a variety of other healthcare delivery contexts. In 2008, for example, researchers published the results of a randomized controlled trial, Improving Mood: Promoting Access to Collaborative Treatment (IMPACT), which was designed to investigate the long-term effects on total healthcare costs of participation in a depression treatment program compared with usual primary care.³¹⁶ Five hundred and fifty-one participants from two IMPACT trial sites who satisfied clinical criteria for either depression or dysthymia were randomly assigned to the IMPACT intervention group or to a usual primary care group.³¹⁷ The patients assigned to the IMPACT group had access for one year to a depression care manager who provided education, behavioral activation, support of antidepressant medication management prescribed by their regularly primary care provider, and problem-solving treatment in primary care for up to twelve months.³¹⁸ The patients assigned to the usual primary care group were told that they met the criteria for major depression or dysthymia and were encouraged to follow up with their primary care provider for treatment.³¹⁹ The researchers obtained from the trial sites cost accounting data that tracked costs associated with all healthcare delivered to the patients.³²⁰

The study authors found that the patients who were assigned to the IMPACT group had lower mean total healthcare costs (\$29,422) over the four-year period compared to the patients who were assigned to the usual-care group (\$32,785), which represented a cost savings among the IMPACT patients of \$3363 per patient on average during four years.³²¹ The IMPACT patients had lower healthcare costs than the usual-care patients in every healthcare cost category observed, including outpatient mental health costs, inpatient mental health costs, outpatient medical costs, inpatient medical and surgical costs, pharmacy costs, and other outpatient costs.³²² The researchers formally concluded that, when compared with usual primary care, the IMPACT program is associated with a high probability of lower total healthcare costs during a four-year period.³²³ The researchers also stated that

³¹³ *Id.* at 1226.

³¹⁴ *Id.*

³¹⁵ *Id.* at 1226, 1230; *see also id.* at 1229 (“After adjustment for baseline differences, health services costs were approximately 50% higher for patients with persistent depression than for patients who reached full remission. This cost difference was spread across all categories of outpatient and inpatient health services. Comparison of visit and hospitalization rates showed the same pattern: consistently higher utilization for those with poorer depression outcomes.”).

³¹⁶ *See* Jürgen Unützer et al., *Long-Term Cost Effects of Collaborative Care for Late-Life Depression*, 14 AM. J. MANAGED CARE 95 (2008).

³¹⁷ *Id.* at 95-96.

³¹⁸ *Id.*

³¹⁹ *Id.* at 96.

³²⁰ *Id.*

³²¹ *Id.* at 95, 98.

³²² *Id.* at 98.

³²³ *Id.* at 95.

their findings support the implementation of programs and policies that facilitate coverage of—and reimbursement for—treatment of mental illnesses such as depression and dysthymia.³²⁴

The studies described above were conducted in populations of patients with traditional mental illnesses, such as depression and dysthymia.³²⁵ Researchers also have investigated the relationship between treatment of other mental illnesses, such as alcohol and drug abuse, and healthcare costs as well as a number of other variables, including employment, drug and alcohol consumption, and criminal activity.³²⁶ These studies show that treating alcohol and drug abuse can yield significant clinical and economic returns on an employer's or public healthcare program's initial treatment investment. For example, a group of researchers published in 2000 the results of a study conducted in the State of Washington that examined the clinical and economic returns on addiction treatment provided to 263 Medicaid-eligible drug addiction treatment clients.³²⁷ The clinical and economic returns were calculated based on an analysis of several variables (each of which was assigned a cost), including number of days experiencing medical problems, overnight hospitalizations for medical treatments, emergency room visits for medical treatment, clinic or physician visits for medical treatments, days experiencing psychological or emotional problems, days in inpatient psychiatric treatment, days in hospital outpatient psychiatric treatment, income received from employment, money spent on alcohol, money spent on drugs, and days engaged in illegal activities.³²⁸ The study demonstrated that each dollar invested in full-continuum (FC) addiction care (defined as care that begins with an inpatient hospital or residential stay, is followed by intensive outpatient services, and is followed by outpatient aftercare) and partial-continuum (PC) addiction care (defined as care that begins with intensive outpatient care and is followed by additional less intensive outpatient care) yielded returns of approximately 9.7 and 23.3 times their initial investments, respectively.³²⁹ The study also demonstrated that the average cost of treatment amounted to \$2530 for FC addiction care and \$1138 for PC addiction care, and that the average economic benefit amounted to \$20,363 for FC addiction care and \$12,130 for PC addiction care, producing a net economic benefit of both FC and PC addiction

³²⁴ *Id.* at 100. For additional information regarding the IMPACT study and the adoption of the IMPACT approach by other healthcare delivery systems due to its cost effectiveness, see generally Justin Reedy, *Team Treatment for Depression Cuts Medical Costs*, UW TODAY (Feb. 7, 2008), <http://www.washington.edu/news/archive/id/39654>. Scientists also have studied the effect of scaling back mental health spending following a period of mental health spending, and their findings continue to support mental health parity. See, e.g., Robert A. Rosenheck et al., *Effect of Declining Mental Health Service Use on Employees of a Large Corporation*, 18 HEALTH AFF. 193, 201 (1999) (finding that general healthcare costs and sick days increased when mental health spending was cut back at one large self-insured company; concluding that, “[p]erhaps the most important implication of this study is that reductions in use of mental health services can be associated with compensatory increases in use of medical services and may adversely affect the functional and health status of patients, with no savings to payers”).

³²⁵ See Simon et al., *supra* note 264; Simon, et al., *supra* note 310; Unützer et al., *supra* note 272; Unützer et al., *Healthcare Costs*, *supra* note 299; Unützer et al., *supra* note 316; Welch et al., *supra* note 285.

³²⁶ See, e.g., Michael T. French et al., *Benefit-Cost Analysis of Residential and Outpatient Addiction Treatment in the State of Washington*, 24 EVALUATION REV. 609, 626 (2000).

³²⁷ See *id.*

³²⁸ See *id.* at 617-18.

³²⁹ See *id.* at 625-26.

care.³³⁰ The study authors formally concluded that their results strongly suggest that both FC and PC addiction care can generate positive and significant net benefits to society.³³¹

In addition to clinically oriented studies that use private health plan and public healthcare program data to show an association between mental illness and total healthcare costs, a second line of research based primarily in economics suggests that the moral hazard concerns associated with mental health parity implementation may have been valid decades ago in the traditional indemnity setting,³³² the same efficiency concerns are less valid under managed healthcare.³³³ This is especially true for managed mental healthcare provided through a behavioral health carve-out plan, which is a specialized managed behavioral health plan that is separate (or carved out) from an employer's or group's regular managed care organization and that has expertise in establishing specialty mental health provider networks, negotiating mental health provider payment rates, and managing utilization to affect the cost and supply of mental health services.³³⁴ The number of behavioral health carve-out plans has increased significantly, perhaps due to the carve-out plans' documented role in reducing inpatient admissions, lengths of stays, and total spending on inpatient care.³³⁵ In theory, managed behavioral health carve-out plans eliminate unnecessary utilization at its source and on a case-by-case basis.³³⁶

In one study published in 1998, three researchers tracked access, utilization, and costs of mental healthcare for a large, private, West Coast-based employer over nine years (1988-1996) during which managed care was introduced and mental health benefits were substantially expanded and carved out of the traditional medical plan by a behavioral health carve-out plan ("U.S. Behavioral Health").³³⁷ In one of the first long-term reports of the cost trend under a managed behavioral health carve-out plan, the study authors reported a forty-three percent lower cost (including the administrative fee charged by U.S. Behavioral Health) per enrollee per month in 1995 than in 1990, the year before the carve-out decision.³³⁸ The study authors attributed the cost savings in part to a decline in inpatient admissions and an

³³⁰ See *id.* at 625.

³³¹ See *id.* at 627 ("It therefore appears that the State of Washington is receiving value for its treatment investments in both clinical and financial terms—at least to the extent that these samples are representative of patients entering treatment.").

³³² See *supra* notes 242-53 and accompanying text.

³³³ *Id.*

³³⁴ 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, 5422 (Feb. 2, 2010) ("Since the early 1990s, many health insurers and employers have made use of specialized vendors, known as behavioral health carve-outs, to manage their mental health and substance abuse benefits. These vendors have specialized expertise in the treatment of mental and addictive disorders and organized specialty networks of providers. These vendors are known as behavioral health carve-outs. They use information technology, clinical algorithms and selective contracts to control spending on mental health and substance abuse treatment."); Barry, *Political Evolution*, *supra* note 37, at 190 (discussing behavioral health carve-out plans); Ma & McGuire, *supra* note 249, at 54.

³³⁵ See, e.g., Barry, *Political Evolution*, *supra* note 37, at 190 (noting growth of carve-out plans); Frank et al., *supra* note 239, at 1702 (noting tendency of carve-out plans to reduce spending); Ma & McGuire, *supra* note 249, at 54 ("The rapidly growing use of separate carve-out contracts has been stimulated by reports of very favorable cost experience for many payers, with some savings reported to be in the range of 40 percent or more." (footnote omitted)).

³³⁶ See, e.g., SURGEON GENERAL REPORT, *supra* note 37, at 423.

³³⁷ See William Goldman, Joyce McCulloch & Roland Sturm, *Costs and Use of Mental Health Services Before and After Managed Care*, 17 HEALTH AFF. 40, 41 (1998).

³³⁸ *Id.* at 45.

increased use of outpatient care.³³⁹ According to the study authors, “[t]he main result is that despite higher initial access to specialty care in the post period and substantially increased benefits, costs for mental healthcare declined dramatically in the first year and continued to decline slowly in the following five years.”³⁴⁰ The study authors concluded that the implementation of mental health parity in a managed behavioral health carve-out setting could yield long-run cost containment and that mental health parity implementation would not “brea[k] the bank.”³⁴¹

In a second study published in 1998, two Boston University economists examined the costs associated with a behavioral health carve-out plan initiated in July 1993 by the Group Insurance Commission (GIC) of the Commonwealth of Massachusetts.³⁴² The economists obtained data from GIC eligibility and health claims files dated July 1991 through June 1995, a period that included two years of pre-carve-out data and two years of post-carve-out data.³⁴³ The economists found a very significant cost reduction after the initiation of the carve-out plan.³⁴⁴ In the two years prior to the initiation of the carve-out plan (1992 and 1993), plan costs were \$16.93 million and \$14.82 million, respectively.³⁴⁵ In the two years following the initiation of the carve-out plan (1994 and 1995), plan costs were \$9.32 million and \$7.29 million, respectively.³⁴⁶ Average GIC payments per participant per month also significantly decreased from \$13.92 in 1992 and \$12.22 in 1993 to \$6.04 in 1994 and \$4.77 in 1995.³⁴⁷ Overall, the economists found a fifty to sixty percent gross reduction in costs and an estimated thirty to forty percent minimum net reduction in costs after adjusting for a number of different trends, including a shifting enrollee case-mix, rising medical prices, and a downward drift in mental health and substance service use.³⁴⁸ The economists formally concluded that “by any standard, the data show a very significant cost reduction after the carve-out.”³⁴⁹

In a third study published in 2008, three researchers from Harvard University investigated the demand response of mental health services to cost-sharing under

³³⁹ *Id.* at 46-47.

³⁴⁰ *Id.* at 48.

³⁴¹ *Id.* (“[S]witching to managed care dramatically reduces costs even if benefits are increased. Moreover, this is not just a one-time cost reduction after which the cost spiral restarts; rather, our data show long-run cost containment.”). For similar conclusions, see also Barry et al., *Political History*, *supra* note 80, at 414-15 (“All the employer groups we interviewed pointed out that this newer research evidence, together with their own experiences with benefit expansion under managed care, contributed to the evolution in their view that comprehensive parity would not break the bank.”); Roland Sturm, Weiyang Zhang & Michael Schoenbaum, *How Expensive Are Unlimited Substance Abuse Benefits Under Managed Care?*, 26 J. BEHAV. HEALTH SERVS. & RESEARCH 203, 210 (1999) (“In contrast to the common belief that unlimited SA [substance abuse] benefits will break the bank and therefore are not a realistic policy option, ‘parity’ for SA in employer-sponsored health plans is affordable under comprehensively managed care.”).

³⁴² See Ma & McGuire, *supra* note 249, at 54.

³⁴³ *Id.* at 62.

³⁴⁴ *Id.* at 63.

³⁴⁵ *Id.*

³⁴⁶ *Id.*

³⁴⁷ *Id.*

³⁴⁸ *Id.* at 64-65.

³⁴⁹ *Id.* at 63. For similar findings, see also Richard G. Frank & Thomas G. McGuire, *Savings from a Medicaid Carve-Out for Mental Health and Substance Abuse Services in Massachusetts*, 48 PSYCHIATRIC SERVS. 1147, 1152 (1997) (“The carve-out program for mental health and substance abuse care in Medicaid in Massachusetts produced substantial savings for the state. Early estimates of savings on the order of 25 percent were essentially maintained throughout the life of the contract, figuring projected expenditures on the basis of medical price inflation.”).

managed healthcare and compared it to the demand response of mental health services to cost-sharing under traditional indemnity (fee-for-service) plans.³⁵⁰ More specifically, the researchers obtained data from the 1996 Medical Expenditure Panel Survey and analyzed the effect of prices on the probability of ambulatory mental health uses.³⁵¹ The researchers found that the effect of the co-insurance rate on ambulatory mental health services demand under managed care plans was significantly smaller than that under indemnity plans and was not significantly different than zero.³⁵² The researchers formally concluded that managed care, not out-of-pocket prices paid by consumers, controls rates of utilization.³⁵³ The researchers also stated in their conclusion that efficiency arguments against mental health parity may not apply to managed care settings.³⁵⁴

In addition to research demonstrating that the moral hazard concerns associated with mental health parity may not apply in the managed care setting, a final line of research examining the actual costs associated with the implementation of mental health parity and mental health and substance use disorder benefits in particular healthcare delivery settings shows that mental health parity implementation has not increased total healthcare delivery costs. One such setting is the FEHBP, the largest employer-sponsored health insurance program in the United States that serves more than eight million federal employees, annuitants, and dependents.³⁵⁵ In January 2001, the FEHBP instituted a mental health and substance abuse parity policy in compliance with a parity order issued by President Clinton in July 1999.³⁵⁶ The parity order required equality between the rates, terms, and conditions (including deductibles, co-payments, inpatient day limitations, and outpatient visit limitations) that applied to the FEHBP's medical and surgical benefits and those that applied to mental health and substance use disorder benefits.³⁵⁷ At the time of its issuance, one concern associated with the parity order was that the FEHBP would incur large increases in both mental health service use and federal spending on mental health services.³⁵⁸ HHS thus commissioned a study to evaluate the effect of the parity order in the FEHBP on costs as well as other important indicators.³⁵⁹ The authors of the commissioned study concluded that the cost concerns were unfounded: "When

³⁵⁰ See Lu et al., *Demand Response*, *supra* note 247, at 113.

³⁵¹ *Id.* at 114.

³⁵² *Id.* at 119-20.

³⁵³ *Id.* at 121.

³⁵⁴ *Id.*; see also Roland Sturm, *How Expensive Is Unlimited Mental Health Care Coverage Under Managed Care?*, 278 JAMA 1533, 1533 (1997) ("Concerns about costs have stifled many health system reform proposals. However, policy decisions were often based on incorrect assumptions and outdated data that led to dramatic overestimates. For mental health care, the cost consequences of improved coverage under managed care, which by now accounts for most private insurance, are relatively minor.").

³⁵⁵ See DEP'T HEALTH & HUMAN SERVS., EVALUATION OF PARITY IN THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM: FINAL REPORT 10 (2004) [hereinafter FEHB FINAL REPORT].

³⁵⁶ *Id.* at 1; Howard H. Goldman et al., *Behavioral Health Insurance Parity for Federal Employees*, 354 NEW ENG. J. MED. 1378, 1379 (2006).

³⁵⁷ FEHB FINAL REPORT, *supra* note 355, at 1.

³⁵⁸ Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5425 (Feb. 2, 2010).

³⁵⁹ See ASSISTANT SEC'Y PLANNING & EVALUATION, DEP'T HEALTH & HUMAN SERVS., GROWTH IN PREMIUMS IN THE FEHBP FROM MENTAL HEALTH PARITY (2005), available at <http://aspe.hhs.gov/health/reports/05/mhsamemo.htm>; FEHB FINAL REPORT, *supra* note 355, at 4, 6 (identifying as key research questions: "Did FEHB plans incur additional expenses in implementing the parity policy?" and "How did the parity policy affect cost of [mental health and substance abuse] care to the beneficiary and [the Office of Personnel Management]?").

coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.”³⁶⁰ The study authors explained that their findings reflected little or no effect of mental health parity implementation on mental health services use and total spending.³⁶¹

The FEHBP is not alone in its mental health parity and mental health and substance use disorder benefit implementation cost experiences. Reports indicate that states with mental health parity legislation and mandatory mental health and substance use disorder benefits have had similar experiences. By several reports, California, Maine, Maryland, Minnesota, North Carolina, Pennsylvania, Rhode Island, South Carolina, and Vermont implemented mental health parity and/or mental health and substance use disorder benefits and subsequently experienced either lower costs or extremely modest cost increases (e.g., nineteen cents per member per month in Vermont) in the first year of implementation.³⁶² Additional studies report that Maryland and North Carolina experienced decreased costs following the implementation of mental health parity and mental health and substance use disorder benefits when such parity coincided with the introduction of managed behavioral healthcare.³⁶³

In summary, employers and insurers have offered a number of different reasons for their disparate physical and mental health insurance benefits or lack of mental health and substance use disorder benefits, including the argument that comprehensive mental health benefits will cause costs to rise. However, as discussed in this Part IV.B, the current health plan literature suggests that untreated mental illness may be associated with increases in total healthcare costs and that treatment of mental illness may be associated with decreases in total healthcare costs. In addition, the current mental health economics literature suggests that managed behavioral healthcare may significantly reduce—if not eliminate—the problem of moral hazard in the context of mental healthcare.³⁶⁴ Finally, recent studies of cost data obtained from healthcare delivery settings in which mental health parity and mental health and substance use disorder benefits has been implemented suggest that mental health benefits may have (at most) negligibly increased or (more typically) decreased total healthcare delivery costs in those settings.³⁶⁵ The current empirical literature thus may not support across-the-board concerns associated with the costs of comprehensive mental health and substance use disorder benefits.

³⁶⁰ Goldman et al., *supra* note 356, at 1378.

³⁶¹ *Id.* at 1385.

³⁶² See Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. at 5425 (summarizing state experiences); MENTAL HEALTH ASS'N OF GREATER ST. LOUIS, WHY MENTAL HEALTH PARITY MAKES SENSE 1 (2004), available at <http://www.mocmhc.org/documents/MHA%20Parity%20Brief.pdf> (“In Minnesota, Blue Cross/Blue Shield reduced its insurance premiums by five to six percent after one year’s experience under the state’s comprehensive parity law In North Carolina, mental health expenses have decreased every year since comprehensive parity for state and local employees was passed in 1992. Mental health costs, as a percentage of total health benefits, have decreased from 6.4 percent in 1992 to 3.1 percent in 1998 Cost analyses of the parity law in Vermont, the most comprehensive parity law in the country, found that for one major health plan, costs increased by 19 cents per member per month, and actually decreased by 9 percent for the other major health plan in the state.” (citation omitted)).

³⁶³ Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. at 5424 (summarizing state experiences).

³⁶⁴ See *supra* notes 244-50 and accompanying text.

³⁶⁵ See, e.g., SURGEON GENERAL REPORT, *supra* note 37, at 428-29.

C. A PROPOSAL FOR COMPREHENSIVE AND SPECIFIC ESSENTIAL MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

The primary theme of the *Workshop Report*, the *Consensus Report*, and the *EHB Bulletin* with respect to all ten of the ACA-required benefit categories was the perceived tension between the comprehensiveness of benefits and healthcare cost increases.³⁶⁶ Likely as a result of the intense focus on this perceived tension, the HHS plan identified in the *EHB Bulletin* is timid with respect to the comprehensiveness and specificity of the EHB Package.³⁶⁷ If HHS's current plan is adopted, states will have broad discretion in defining the EHB Package (including, perhaps, a Package that contains modest mental health and substance use disorder benefits), health plans will have flexibility in adjusting benchmarked benefits (including adjustments that could further reduce mental health and substance use disorder benefits), and health plans may be permitted to substitute services within and across benefit categories (including substitutions away from mental health and substance use disorder services and toward services in one or more of the other nine ACA-required benefit categories).³⁶⁸

This Part IV has shown that the intense focus on the perceived relationship between the comprehensiveness of benefits and healthcare cost increases in the *Workshop Report*, *Consensus Report*, and *EHB Bulletin* might be misplaced in the context of mental health and substance use disorder benefits. This Article thus proposes that HHS consider adopting a comprehensive essential mental health and substance use disorder benefit that includes, at a minimum, medically necessary and evidence-based inpatient and outpatient mental healthcare services, inpatient substance abuse detoxification services, inpatient and outpatient substance abuse rehabilitation services, emergency mental healthcare services, prescription drugs for mental health conditions, psychiatric disease management participation, and community-based mental healthcare services. The current literature suggests that the provision of these services to mentally ill individuals who need them may, in the long run, decrease or not increase total healthcare expenditures.

One question that remains is how specific the EHB Package should be in terms of the required mental health and substance use services. For example, should regulations implementing the EHB Package specifically list the health conditions or medical or other criteria for which particular mental health treatments, such as individual psychotherapy, group counseling, particular name brand or generic psychiatric drugs, electroconvulsive therapy, deep brain stimulation, or inpatient detoxification and rehabilitation services, will be covered? As background, the "specific v. flexible" debate in healthcare reform is a perennial issue. The Clinton administration's failed but incredibly specific Health Security Act of 1993 contained a sixty-one-page enumerated list of covered benefits.³⁶⁹ Both the FEHBP and the Massachusetts Health Care Reform Law, on the other hand, contain broadly defined benefit categories.³⁷⁰ The value of specificity versus flexibility continues to be debated, including in the statements made by speakers at the IOM workshops. On behalf of the American Congress of Obstetricians and Gynecologists, for example,

³⁶⁶ See *supra* notes 156, 232-36 and accompanying text.

³⁶⁷ EHB BULLETIN, *supra* note 23.

³⁶⁸ See *id.* at 12.

³⁶⁹ WORKSHOP REPORT, *supra* note 10, at 22; see Health Security Act of 1993, H.R. 3600, 103d Cong.

³⁷⁰ WORKSHOP REPORT, *supra* note 10, at 20.

Dr. Arnold Cohen stated that describing the EHB as specifically as possible “is the surest way to protect our patients against potential conflict or debate regarding medical necessity.”³⁷¹ On the other hand, Ms. Katy Spangler, a Staff Member of the Senate Health, Education, Labor, and Pensions Committee, referred to the ten ACA-required benefit categories as “buckets of care” and explained that they were “intentionally left vague so that details of what plans would cover could be left to the marketplace.”³⁷² Dr. Rex Cowdry of the Maryland Health Care Commission cautioned the Committee against “too much design specificity or standardization,” as this “prevents the kind of innovation needed to control health care costs.”³⁷³ Dr. David Guzick, Senior Vice President for Health Affairs and President of the University of Florida Shands Health System, urged the Committee to leave condition-specific decisions to the marketplace in order “to reflect evolving clinical knowledge, appropriate practices, and appropriate oversight at the state level by insurance commissioners.”³⁷⁴ Other stakeholders also believed that a flexible EHB Package would allow for innovation, including advances in technology and treatments.³⁷⁵

On one hand, the literature discussed at Part IV.B suggests clinical and cost benefits of particular medically necessary mental health treatments and services, such as the disease management services provided to the individuals who participated in the IMPACT (2008) study³⁷⁶ and the FC and PC addiction care services provided to the individuals who participated in the State of Washington (2000) study.³⁷⁷ On the other hand, the evidence base for mental health and substance abuse care is rapidly changing and the ability of HHS or a state to update specific lists of services that are tied to specific health conditions, medical criteria, or other criteria may be unrealistic. I thus propose that the initial EHB Package include at least the following specific categories of mental health and substance abuse disorder services: inpatient and outpatient mental healthcare services, inpatient substance abuse detoxification services, inpatient and outpatient substance abuse rehabilitation services, emergency mental healthcare services, prescription drugs for mental health conditions, psychiatric disease management programs, and community-based mental healthcare services. I further propose that these specific categories of mental health and substance use disorder benefits, and any specific treatments or services provided under each category, be reviewed regularly to ensure a basis in the current medical and scientific literatures. I finally propose that the mental healthcare treatment and cost literature be reviewed on a regular basis. Should the findings of the mental healthcare treatment and cost literature change such that an initial mental health treatment investment is no longer a long-term value with respect to total healthcare costs (either due to changes in the way in which mental healthcare is managed, changes in the relationship between the cost of currently experimental but possibly future mental health treatments (such as deep brain stimulation) compared to total healthcare costs, or changes in any other variable), the proposals in this Article may need to be revisited.

³⁷¹ *Id.* at 6.

³⁷² *Id.*

³⁷³ *Id.*

³⁷⁴ *Id.* at 20.

³⁷⁵ *Id.* at 21.

³⁷⁶ *Supra* note 323-24.

³⁷⁷ *Supra* note 331.