


2012

All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law

Stacey A. Tovino

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

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

 Part of the [Health Law Commons](#), [Insurance Law Commons](#), [Medical Jurisprudence Commons](#), and the [Psychology and Psychiatry Commons](#)

Recommended Citation

Tovino, Stacey A., "All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law" (2012). *Scholarly Works*. Paper 688.

<http://scholars.law.unlv.edu/facpub/688>

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

ARTICLE

ALL ILLNESSES ARE (NOT) CREATED EQUAL: REFORMING FEDERAL MENTAL HEALTH INSURANCE LAW

STACEY A. TOVINO*

This Article is the second, and most important, installment in a three-part series that presents a comprehensive challenge to lingering legal distinctions between physical and mental illness. The basic impetus for this historical, medical, and legal project is a belief that there exists no rational or consistent method of distinguishing physical and mental illness in the context of health insurance law. The first installment in this series narrowly inquired as to whether a particular set of disorders, the postpartum mood disorders, are or should be classified as physical or mental illnesses in a range of health law contexts.¹ This second installment is broader in scope and challenges the less comprehensive public and private health insurance benefits that are available to individuals who have illnesses traditionally classified as mental. In so doing, this Article proposes a reform of federal mental health insurance law. The third and final piece in the series undertakes a necessary correction of state mental health parity law.² Throughout this three-part project, the aim is to bring greater attention to the origins and evolution of the concept of health and to discredit the notion that individuals with mental health conditions are less deserving of legal protection and benefits than individuals with physical health conditions. The purpose of this particular piece is to explore in greater detail the reasons offered by legislators, regulators, judges, insurers, and other stakeholders for providing less comprehensive insurance benefits for individuals with mental illness, and to question the logic, scientific bases, and empirical accuracy of these reasons. In the end, this Article argues that federal health insurance law should not continue to discriminate against individuals with mental illness without adequate justification. Finding none, this Article proposes a reform of federal mental health insurance law.

* Professor of Law, William S. Boyd School of Law, University of Nevada, Las Vegas. B.A., Tulane University, 1994; J.D., University of Houston Law Center, 1997; Ph.D., University of Texas Medical Branch, 2006. I thank John Valery White, (Dean, William S. Boyd School of Law), for his financial support of this research project. I also thank Jeanne Price (Director, Wiener-Rogers Law Library), Chad Schatzle (Reference Librarian, Wiener-Rogers Law Library), and Michael Vargas (former student at Boyd School of Law) for their outstanding assistance in locating many of the medical, scientific, and other sources referenced in this Article. I further thank the participants of the following symposia and meetings for their helpful comments and suggestions on earlier drafts of this Article: The 26th Annual Whittier Health Law Symposium of Whittier Law School; The 63rd Annual Meeting of the Southeastern Association for Law Schools; and The 33rd Annual Health Law Professors Conference sponsored by the American Society for Law, Medicine & Ethics.

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

² See Stacey A. Tovino, *Reforming State Mental Health Parity Law*, HOUS. J. HEALTH L. & POL'Y (forthcoming 2011) [hereinafter Tovino, *Reforming*].

I. INTRODUCTION

Public health care programs and private health insurers have long provided less comprehensive insurance benefits to individuals with mental illness. This Article proposes to reform federal health insurance law by removing statutory and regulatory provisions that allow for unequal physical and mental health insurance benefits. Part II of this Article begins by analyzing the justifications provided by public health care programs and private health insurers for providing inferior insurance benefits for individuals with mental illness, including allegations that mental health care is more costly and less efficacious than physical health care. These reasons are not supported in the relevant clinical, economic, and social literatures. The current health plan cost literature shows that untreated mental illness is associated with increases in total health care costs, while treatment of mental illness is associated with decreases in total health care costs. The current mental health economics literature shows that managed behavioral health care significantly reduces if not eliminates the problem of moral hazard in the context of mental health care. Recent studies of cost data obtained from health care delivery settings in which mental health parity has been implemented show that mental health parity implementation has not increased total health care delivery costs.

In Part III, this Article addresses other implications of mental health benefit disparities that often go unconsidered by policymakers. Recent studies of the relationship between untreated mental illness and other variables, including employment, disability, homelessness, welfare, and crime, show that individuals with untreated mental illness have not only higher total health care costs but also lower rates of work productivity, higher rates of disability, higher rates of homelessness, higher rates of welfare, and higher rates of criminal activity, suggesting significant employer and public program returns on initial mental health treatment investments. In addition, mental health benefit disparities have proven unmanageable in the context of health insurance coverage litigation. Despite judicial attempts to distinguish physical and mental illnesses based on a number of different tests that inquire into the area of specialization of the treating health care provider, the nature and type of treatment, the origin of the illness, and the symptoms of the illness, none of these tests provides a rational or consistent method of distinguishing physical and mental illness.³

³ Outside the context of mental health insurance law (including in the contexts of disability discrimination law, civil rights and human rights law, health information confidentiality law, health care reform law, and child and adult health and welfare law) individuals with mental illness are not subject to inferior legal protections or benefits. See Stacey A. Tovino, *Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits*, 22 ANNALS HEALTH L. (forthcoming 2012). Moreover, the international, national, state, and professional definitions of “health” that are used in a range of clinical, legal, and social contexts uniformly fail to subordinate mental health to physical health and that these definitions identify both physical wellness and mental wellness as equal

In Part IV, this Article examines the incomplete development of federal mental health parity law beginning with President Clinton's Mental Health Parity Act of 1996,⁴ continuing with President George W. Bush's Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,⁵ and concluding with President Obama's Affordable Care Act of 2010.⁶ The final part of this Article proposes the extension of federal mental health parity law and mandatory mental health and substance use disorder benefits to all individuals with public and private health insurance who do not currently benefit from such legislation.

A. *Inferior Insurance Benefits for Individuals with Mental Illness*

Public health care programs and private health insurers have long provided less comprehensive insurance benefits to individuals with mental illness in both the inpatient⁷ and outpatient⁸ settings.⁹ The Medicare program, a public health care program funded and administered by the United States government, provides health insurance for individuals who are sixty-five

contributors to overall health. *Id.* The remaining legal distinctions between physical and mental illness may emanate from the centuries-old mind-body problem, which continues to animate health law, philosophy of the mind, and other legal and philosophical doctrine. *Id.* Finally, the stigma associated with mental illness may be serving as a formidable obstacle to mental health parity even when all other obstacles have been removed. *Id.*

⁴ Mental Health Parity Act of 1996, Pub. L. No. 104-204, secs. 701-03, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)) [hereinafter MHPA]. *See generally infra* Part IV.A.

⁵ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, in Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, secs. 511-12, 122 Stat. 3765, 3881-93 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)) [hereinafter MHPAEA]. *See generally infra* Part IV.B.

⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *as amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) (codified as amended in scattered sections of U.S.C.) [hereinafter ACA]. *See generally infra* Part IV.C.

⁷ 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).

⁸ 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.*

⁹ *See, e.g.,* DEPT HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., 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."); "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.").

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.¹⁰ Both Medicare Part A, which provides hospital insurance benefits,¹¹ and Medicare Part B, which provides physician and other supplementary medical insurance benefits,¹² 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 freestanding psychiatric hospital but places no lifetime maximum on the number of days a beneficiary may stay as an inpatient in a non-psychiatric hospital.¹³ The federal government justifies the 190-day limitation as a cost-control measure.¹⁴ 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.¹⁵ With the limitation, affected beneficiaries are limited to: (1) Medicare-covered outpatient mental health care, 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.¹⁶ Some beneficiaries who consider unsatisfactory the options of outpatient mental health care or inpatient care in a

¹⁰ See 42 U.S.C. § 1395c (2006). See generally Dep't Health & Human Servs., Ctrs. Medicare & Medicaid Servs., *What Is Medicare?* CMS PUB. NO. 11306 (Apr. 2008).

¹¹ See 42 U.S.C. §§ 1395c-1395i-5 (2006 & Supp. IV 2010) (establishing "[Medicare] Part A—Hospital Insurance Benefits for Aged and Disabled").

¹² See 42 U.S.C. §§ 1395j-1395w-4 (2006 & Supp. IV 2010) (establishing "[Medicare] Part B—Supplementary Medical Insurance Benefits for Aged and Disabled").

¹³ See 42 C.F.R. § 409.62 (2010); see also NAT'L POL'Y FORUM, *MEDICARE'S MENTAL HEALTH BENEFITS 1* (Feb., 2007); CONG. BUDGET OFFICE, CBO STAFF MEMORANDUM: *THE INPATIENT PSYCHIATRIC HOSPITAL BENEFIT UNDER MEDICARE 4-5* (July 1993) [hereinafter CBO MEMORANDUM].

¹⁴ See Judith R. Lave & Howard H. Goldman, *Medicare Financing for Mental Health Care*, HEALTH AFF. Feb. 1990, at 19, 21 ("This limit assures that Medicare will not pay for the long-term custodial support of the mentally ill."); NAT'L POL'Y FORUM, *supra* note 13 (explaining that Medicare Part A's 190-day lifetime maximum on mental health care provided in a freestanding psychiatric hospital was intended to limit the federal government's mental health care costs).

¹⁵ See, e.g., Letter from Michael J. Fitzpatrick, Exec. Dir., Nat'l Alliance on Mental Illness, to Rep. Paul Tonko (D-N.Y.) (Sept. 20, 2010), available at http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=107512 (explaining that many nonelderly Medicare beneficiaries with disabilities have already exceeded the 190-day limit or are at imminent risk of doing so).

¹⁶ CBO MEMORANDUM, *supra* note 13, 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); CBO MEMORANDUM, *supra* note 13, 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 SHARING FOR 2011* (2010), available at <http://www.cahealthadvocates.org/basics/benefits-summary>.

non-psychiatric setting may forgo mental health care entirely if they are unable to pay 100% of the costs of inpatient care provided in a psychiatric setting.¹⁷

In addition to the Medicare Part A limitation on inpatient care provided in a freestanding psychiatric hospital, Medicare Part B also provides less comprehensive outpatient mental health benefits than non-mental health benefits. In particular, Medicare Part B currently imposes a 45% beneficiary coinsurance¹⁸ on most outpatient mental health services, including individual, family, and group psychotherapy services, instead of the 20% beneficiary coinsurance traditionally applied to non-mental health outpatient services.¹⁹ Although Medicare will phase out the disparate coinsurances by the year 2014, Medicare beneficiaries who receive outpatient mental health services between the present and 2014, will be required to pay out of their own pockets 15–35% more of the cost of those services than of non-mental health services.²⁰

The Medicaid Program, a public health care program jointly funded by the federal and state governments and administered by the states, provides health care to certain low-income individuals and families who fit into an eligibility group recognized by federal and state law.²¹ Like the Medicare Program, the Medicaid Program also has limited support for individuals who

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).

¹⁷ CBO MEMORANDUM, *supra* note 13, 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.”).

¹⁸ Although no health insurance-related federal statute or regulation defines “coinsurance,” it may be defined as the insured’s liability after the insurer has paid its portion of the total health care costs. See DEP’T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., MEDIGAP COVERAGE OF OUTPATIENT MENTAL HEALTH SERVICES THAT ARE SUBJECT TO THE MENTAL HEALTH PAYMENT REDUCTION 6 n.ix (Dec. 2002) (defining coinsurance without reference to a statute or regulation and with respect to common parlance, that is, the beneficiary’s liability after Medicare payment is made).

¹⁹ See 42 U.S.C. § 1395I(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 coinsurance), 75% in 2012 (resulting in a 40% beneficiary coinsurance), 81.25% in 2013 (resulting in a 35% beneficiary coinsurance), and 100% in 2014 and thereafter (resulting in a 20% coinsurance). By 2014, Medicare thus will pay 80% of (and Medicare beneficiaries will pay a 20% coinsurance 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 (entitled, “Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services”).

²⁰ See 42 U.S.C. § 1395I(c) (2006 & Supp. IV 2010).

²¹ 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.”); DEP’T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., MEDICAID PRO-

require mental health care in certain inpatient psychiatric settings. For example, Medicaid does not cover inpatient mental health care provided to individuals age twenty-two through sixty-four in an institution for mental disease (“IMD”),²² 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.²³ Medicaid also does not cover mental health care provided in small residential facilities, including halfway houses, adult residential foster homes, and crisis centers.²⁴ Due to these limitations, many Medicaid beneficiaries are limited to: (1) Medicaid-covered outpatient mental health care, 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. Because Medicaid eligibility generally requires evidence of low income,²⁵ most Medicaid beneficiaries will not be able to pay 100% of the cost of treatment in an IMD or small residential facility.²⁶

Private health insurers also have a long history of providing less comprehensive insurance benefits to individuals with mental illness.²⁷ Traditionally, many private insurers did not cover mental illness.²⁸ Notwithstanding

GRAM—GENERAL INFORMATION, http://www.cms.gov/medicaidgeninfo/01_overview.asp? (last updated Jun. 16, 2011) [hereinafter MEDICAID PROGRAM].

²² See 42 C.F.R. § 435.1009(a)(2) (2006) (prohibiting Medicaid coverage of health care services provided to individuals under age sixty-five who are patients in an institution for mental disease).

²³ See 42 U.S.C. § 1396d(i) (2006 & Supp. IV 2010) (defining institution for mental disease).

²⁴ See, e.g., Carl A. Taube, Howard H. Goldman & David Salkever, *Medicaid Coverage for Mental Illness: Balancing Access and Costs*, HEALTH AFF., Feb. 1990, at 5, 8 (1990).

²⁵ See, e.g., MEDICAID PROGRAM, *supra* note 21.

²⁶ Costs of inpatient care provided in a psychiatric setting can exceed \$1,000 per day in a public facility and \$2,000 per day in a private facility. See, e.g., Meg Kissinger, *Mental Facility's Size Cost Taxpayers Millions*, MILWAUKEE WISCONSIN J. SENTINEL, Nov. 13, 2010 (stating that the cost of inpatient care at Milwaukee County Mental Health Complex, a public psychiatric hospital located in Milwaukee, Wisconsin, is \$1,082 per day); \$58,752 for 18 Days of Involuntary Commitment to Mental Hospital, BIPOLAR: CRAZY MERMAID'S BLOG (Aug. 14, 2010), <http://crazymyer1.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 \$2,468 and \$3,900 per day).

²⁷ See, e.g., Colleen L. Barry et al., *Design of Mental Health Benefits: Still Unequal After All These Years*, HEALTH AFF., Sept. 2003, at 127, 127 [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).

²⁸ SURGEON GENERAL REPORT, *supra* note 9, at 418 (“Some private insurers refused to cover mental illness treatment.”).

the efforts of mental health parity advocates,²⁹ neither the federal Mental Health Parity Act of 1996 (“MHPA”)³⁰ nor the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)³¹ required private insurers to offer insurance benefits for mental illness.³² Before President Obama signed the health care reform bill into law and unless otherwise prohibited by state law, private health insurers were permitted to sell individual policies and group health insurance 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.³³ Under the Patient Protection and Affordable Care Act of 2010 (“PPACA”) as reconciled by the Health Care and Education Reconciliation Act (as consolidated, the Affordable Care Act (“ACA”)), mental health and substance use disorder benefits must be part of the essential benefit package offered in the exchange-offered qualified health plan setting,³⁴ the non-exchange individual health plan setting, the non-exchange small group health plan setting, the Medicaid state plan setting, and the Medicaid benchmark

²⁹ Mental health parity advocates support the financing of mental health care on the same basis as the financing of physical health care. *See, e.g.,* SURGEON GENERAL REPORT, *supra* note 9, 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).

³⁰ MHPA, Pub. L. No. 104-204, secs. 701–03, 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)).

³¹ MHPAEA, Pub. L. No. 110-343, Subtitle B, secs. 511–12, 122 Stat. 3756, 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)).

³² *See* 29 U.S.C. § 1185a(b)(1) (2006 & Supp. IV 2010) (“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) (2006 & Supp. IV 2010).

³³ *See* 29 U.S.C. § 1185a(b)(1) (2006 & Supp. IV 2010); 42 U.S.C. § 300gg-26(b)(1) (2006 & Supp. IV 2010). 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)–(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).

³⁴ 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 contain certain “essential health benefits,” defined to include mental health and substance use disorder benefits, by the same date. *See Essential Health Benefits*, HEALTHCARE.GOV, <http://www.healthcare.gov/glossary/e/essential.html> (last visited Nov. 3, 2011).

and benchmark-equivalent plan setting.³⁵ However, as discussed in more detail in Part IV.C, below, the essential health benefits requirement does not apply in the grandfathered health plan setting, the non-exchange large group health plan setting, and the self-insured group health plan setting.³⁶ Even after health care reform, then, millions of insureds still do not have a federal legal right to mandatory mental health and substance use disorder benefits.³⁷

Prior to health care reform, 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, copayments, and coinsurance amounts for mental health care,³⁸ as well as lower inpatient day and outpatient visit limitations and annual and lifetime spending caps for mental health care.³⁹ Although MHPAEA requires parity between physical health benefits and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, and outpatient visit limitations,⁴⁰ as discussed below in Part IV.B, it only regulates large group health plans, not small group health plans.⁴¹ MHPAEA also does 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.⁴² Before ACA and unless otherwise prohibited by state law, many public health care programs and private health plans thus were permitted to contain disparate mental health benefits.⁴³ Although ACA broadened the application of

³⁵ See *infra* notes 270–274 and accompanying text.

³⁶ See *infra* notes 275–285 and accompanying text.

³⁷ See *infra* notes 275–285 and accompanying text.

³⁸ See *supra* notes 19–20 and accompanying text. On the other hand, many health maintenance organizations provide 100% insurance (that is, they require no coinsurance) for preventive care or routine care that is provided on an in-network basis. See, e.g., *Working to Keep You Well*, HEALTH PLAN OF NEVADA, BENEFITS (2010), available at <http://www.healthplanofnevada.com/documents/working%20to%20keep%20you%20well.pdf> (requiring no coinsurance for Tier I health care services).

³⁹ See, e.g., SURGEON GENERAL REPORT, *supra* note 9, at 426–27 (summarizing typical mental health benefit disparities that existed in 1997: “[T]he most common insurance restriction was an annual limit on inpatient days”); Barry, *Political Evolution*, *supra* note 9, at 186 (“In 1982, 31% of full-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 29, 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).

⁴⁰ See *infra* notes 252–257 and accompanying text.

⁴¹ See *infra* notes 245–246 and accompanying text.

⁴² See *infra* note 246 and accompanying text.

⁴³ 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, copayments, coinsurance, inpatient day limitations, and outpatient visit limitations. See, e.g., 24 ME. REV. STAT. ANN. tit. 24, § 2325-A(5-C)(B)(1) (2010) (requiring health insurance policies is-

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,⁴⁴ some small group health 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.⁴⁵ Even after the full implementation of health care reform, then, most public health care program beneficiaries and some individuals with private health insurance still do not have a federal legal right to equal physical health and mental health insurance benefits.⁴⁶

II. UNEQUAL BENEFITS: REASONS AND RESPONSES

Public health care programs and private insurers offer a number of different justifications for their disparate physical and mental health insurance benefits. The reason given most frequently is that mandatory mental health and substance use disorder benefits and mental health parity will cause insurers’ costs to rise.⁴⁷ As background, health insurers frequently focus on the

sued 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 coinsurance 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 INS. § 15-802(c) (2010) (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).

⁴⁴ See *infra* note 264 and accompanying text.

⁴⁵ See *infra* notes 231–232 and accompanying text.

⁴⁶ See *infra* notes 231–232 and accompanying text.

⁴⁷ 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 Pol’y, 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 9, 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 9, 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, *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 29, at 337 (“Opponents of mental health parity . . . cite studies and reports that demonstrate that mental health parity

problems of moral hazard and adverse selection when justifying mental health benefit disparities.⁴⁸ In the context of mental health care, moral hazard refers to the concern that individuals who do not pay for 100% of the cost of their own mental health care will use more mental health services because they do not value these services at their full cost.⁴⁹ To control moral hazard in the context of mental health care, insurers traditionally have imposed lower inpatient day and outpatient visit maximums, as well as higher deductibles, copayments, and coinsurance amounts, on mental health care.⁵⁰ Notwithstanding insurers' concerns regarding moral hazard in the context of mental health care, many of which may be linked to the three-decades-old RAND Health Insurance Experiment,⁵¹ 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

will result in a significant increase in the cost of employee insurance coverage.”); Nelson, *supra* note 39, at 106.

⁴⁸ 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 9, at 420 (discussing the concepts of moral hazard and adverse selection in the context of mental health insurance); Frank et al., *supra* note 47, at 1701–02.

⁴⁹ See, e.g., SURGEON GENERAL REPORT, *supra* note 9, at 420 (discussing the concept of moral hazard in the context of mental health care); 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*].

⁵⁰ See SURGEON GENERAL REPORT, *supra* note 9, at 420; see also Barry et al., *Still Unequal*, *supra* note 27, 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.”); *supra* notes 38–39 and accompanying text.

⁵¹ 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 health care costs, utilization, and outcomes. The HIE, frequently referred to as the largest health policy study in United States 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 CORPORATION, THE HEALTH INSURANCE EXPERIMENT (2006) (summarizing the HIE's principal questions and findings). The study's applicability to today's managed-care dominated health care 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. 5410, 5424 (Feb. 2, 2010).

twenty-five to thirty years ago.⁵² Recent studies also suggest that deductibles (in both the traditional indemnity⁵³ and managed care⁵⁴ settings) and coinsurance amounts (in the managed care setting) have no impact and very little impact, respectively, on the demand for mental health care.⁵⁵ Additional studies that analyze the impact of managed health care and behavioral health carve-out plans⁵⁶ on demand for mental health care suggest that the implementation of managed behavioral health care undermines the assumed demand response as an efficiency argument against parity.⁵⁷ As a result, economists now suggest that the imposition of higher deductibles, copayments, and coinsurance amounts on mental health care may no longer be justified on efficiency grounds and that the traditional practice of unequal health insurance benefit sets may need to be revisited.⁵⁸

Insurers also are concerned with adverse selection; that is, the concern that in a health care market with voluntary insurance or multiple insurers, plans that offer generous mental health benefits will attract individuals with greater mental health care needs, leading to higher service usage and costs

⁵² See, e.g., Chad D. Meyerhoefer & Samuel 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”; concluding, “[t]his suggests that concerns over moral hazard alone do not warrant less generous coverage for mental health.”).

⁵³ 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 (e.g., \$1,000–4,000) and coinsurance amounts (e.g., 20–25%).

⁵⁴ In a managed care plan, enrollees usually are assigned to a primary care provider who must preauthorize access to a specialty health care provider. Managed care plan enrollees typically pay a small co-payment (e.g., \$10, \$15, or \$25) for each visit to a primary care or specialty care provider instead of a high deductible combined with coinsurance. 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, health care is rationed and health care 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).

⁵⁵ 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*].

⁵⁶ See *infra* notes 147–149 and accompanying text for a discussion of behavioral health carve-out plans.

⁵⁷ See, e.g., Frank & McGuire, *Parity*, *supra* note 49, 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*, HEALTH AFF., Mar. 1998, at 53, 56–64 (reporting studies in Massachusetts Medicaid and other contexts showing an association between behavioral health carve-outs and significant savings (e.g., 25–60%) per enrollee due to the virtual elimination of inpatient treatment).

⁵⁸ See Meyerhoefer & Zuvekas, *supra* note 52, at 24.

for those insurers.⁵⁹ Historically, many insurers have not offered mental health benefits as a way of controlling adverse selection.⁶⁰ Of course, the two pre-conditions to adverse selection (voluntary insurance and multiple insurers) were at the heart of the U.S. health care reform debate.⁶¹ Although Congress elected not to proceed with a single-payer system, President Obama's health care reform bill requires all individuals to maintain minimum essential health insurance coverage⁶² and requires exchange-offered qualified health plans, non-exchange individual health plans, non-exchange small health plans, Medicaid state plans, Medicaid benchmark plans, and benchmark-equivalent plans to include mental health and substance use disorder benefits in their essential health benefit packages.⁶³ If upheld,⁶⁴ these health care reform provisions will lessen insurers' risks relating to adverse selection beginning in the year 2014, when the requirements become effective.⁶⁵

Perceived moral hazard and adverse selection concerns may continue to exist post-health care reform because the reform bill does not require certain categories of health plans to include mental health and substance use disorder benefits.⁶⁶ Health insurers that are exempt from mandatory mental health

⁵⁹ See, e.g., SURGEON GENERAL REPORT, *supra* note 9, at 420 (discussing adverse selection in the context of mental health care); Frank & McGuire, *Parity*, *supra* note 49, at 156.

⁶⁰ SURGEON GENERAL REPORT, *supra* note 9, at 420; see also Barry et al., *Still Unequal*, *supra* note 27, at 134 (discussing adverse selection in the context of mental health care; 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.").

⁶¹ 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).

⁶² See ACA, Pub. L. No. 111-148, sec. 1501(b), § 5000A(a), 124 Stat. 119 (2010), *as amended* by 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.").

⁶³ See *infra* notes 270–274 and accompanying text.

⁶⁴ The health care reform bill has been declared unconstitutional by both federal district courts and federal circuit courts of appeal. See, e.g., Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla.), *order clarified*, 780 F. Supp. 2d 1307 (N.D. Fla.), *aff'd in part, rev'd in part sub nom.* Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011), *cert. granted* (U.S. Nov. 14, 2011) (Nos. 11-393, 11-398, 11-400).

⁶⁵ See, e.g., Frank et al., *supra* note 47, 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.").

⁶⁶ See *infra* notes 231–232, 275–285 and accompanying text; see also BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41069, SELF-INSURED HEALTH INSURANCE COVERAGE 5 (May 12, 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.").

and substance use disorder benefits and federal mental health parity law may continue to impose mental health benefit restrictions in an attempt to control perceived moral hazard and adverse selection concerns without recognizing the negative clinical and related cost implications of their benefit restrictions and without taking into account the role of managed care in minimizing moral hazard and other efficiency concerns.⁶⁷

First, although mental health benefit restrictions may reduce inappropriate or unnecessary mental health care, mental health benefit restrictions also have been shown to reduce appropriate outpatient and inpatient mental health care.⁶⁸ Consider an individual who is a member of a health plan to which mental health parity law does not apply and who is being treated on an outpatient basis with counseling, pharmacotherapy, and rehabilitation services for a severe and persistent mental illness, such as schizoaffective disorder.⁶⁹ When the individual reaches her annual outpatient visit maximum, perhaps after four or five months, she may discontinue her outpatient care if she cannot afford to pay 100% of the cost of such care out of her own pocket.⁷⁰ Shortly thereafter, the individual may become floridly psychotic and require admission to an inpatient psychiatric unit.⁷¹ Thirty or sixty days later, when the individual reaches her annual inpatient day maximum, she may be discharged from the inpatient hospital unit, but shortly thereafter may present to the most expensive setting for health care delivery—the

⁶⁷ See, e.g., Goplerud Statement, *supra* note 47, 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 health care); SURGEON GENERAL REPORT, *supra* note 9, at 420 (discussing the clinical implications of mental health benefit restrictions).

⁶⁸ See, e.g., SURGEON GENERAL REPORT, *supra* note 9, at 457 (“Financial obstacles discourage people from seeking treatment and from staying in treatment. Repeated surveys have shown that concerns about the cost of care are among the foremost reasons why people do not seek care.”). Even the RAND study, which insurers have cited in support of the moral hazard theory, found that cost sharing reduces the use of effective health care. See RAND CORPORATION, *supra* note 51, at 4.

⁶⁹ 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) (explaining that severe and persistent mental illnesses, including schizophrenia, bipolar disorder, and chronic major depression require prolonged, and sometimes lifetime, maintenance treatment that consists of pharmacotherapy, supportive counseling, and often rehabilitation services).

⁷⁰ See, e.g., *id.*

The most common visit limits under current insurance arrangements are those for 20 visits per year. That means assuming a minimal approach to treatment of one visit per week, people with severe and persistent mental disorders will exhaust their coverage in about five months. This often results in people foregoing outpatient treatment and a higher likelihood of non-adherence to treatment regimes that produce poor outcomes and the potential for increased hospitalization costs.

Id.

⁷¹ See *id.*

emergency room—following a suicide attempt.⁷² Individuals with mental health insurance benefit disparities are not discouraged from presenting (and ambulances are not discouraged from transporting patients) to the emergency room following a suicide attempt or other psychiatric emergency because federal law requires all Medicare-participating hospitals with an emergency department to provide any individual who requests examination or treatment an appropriate medical screening examination and, if the individual is determined to have an emergency medical or psychiatric condition, necessary stabilizing treatment or an appropriate transfer to another medical facility, regardless of the individual's ability to pay.⁷³ In summary, outpatient mental health benefit restrictions can increase more costly inpatient mental health care usage, and inpatient mental health benefit restrictions can increase costly emergency room usage.⁷⁴

Although the scenario described above is a hypothetical, it is drawn from the current clinical and economic literatures. As described in more detail below, a number of studies show that mental health benefit restrictions are associated with a lack of access to mental health care and untreated mental illness.⁷⁵ Studies also show that untreated mental illness can increase total health care 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 illness⁷⁶ and because untreated mental illness can worsen the

⁷² See *id.* (explaining that implementation of mental health parity potentially could reduce emergency room use by ensuring that benefits for individuals with serious mental illness are not terminated); Leah Carlson Shepherd, *More Patients Heading to the Emergency Room*, EMP. BENEFITS NEWS, Oct. 1, 2008, <http://ebn.benefitnews.com/news/more-patients-heading-emergency-room-711231-1.html> (quoting Paul Fronstin, Director of the Health Research and Education Program at the Employee Benefit Research Institute as stating, "The ER is the most expensive setting for people to get care.").

⁷³ See 42 U.S.C. §§ 1395dd(a), 1395dd(b)(1) (2006); 42 C.F.R. § 489.24(b)(1) (2010) (defining "emergency medical condition" to include "a medical condition manifesting itself by acute symptoms of sufficient severity (including . . . psychiatric disturbances and/or symptoms of substance abuse) . . .").

⁷⁴ See, e.g., Goplerud Statement, *supra* note 47, at 9 (discussing a Minnesota study finding that the state's elimination of its outpatient substance abuse insurance benefit limitations resulted in a decrease in inpatient hospital and emergency room usage by individuals with substance abuse conditions); 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) (explaining that parity in a world dominated by managed behavioral carve-outs has resulted in reduced rates of hospitalization and fewer very long episodes of outpatient care); Saul Feldman et al., *Mental Health Parity: A Review of Research and a Bibliography*, 29 ADMIN. & POL'Y MENTAL HEALTH 215, 216 (2002) ("Several studies have shown that when benefit parity is introduced with managed care, a larger percentage of adults and children access outpatient services. However, the overall number of outpatient visits does not increase, and inpatient admissions and lengths of stay decrease.").

⁷⁵ 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.").

⁷⁶ 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, 5423–24 (Feb. 2, 2010)

prognosis of, prolong the period of recovery from, and increase the risk of mortality associated with physical illness.⁷⁷ Finally, a number of studies suggest that treating mental illness can decrease total health care costs.⁷⁸ Representative studies are examined below.

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.⁷⁹ 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 health care costs as part of any policy recommendation or initiative.⁸⁰ The researchers thus set out to investigate the relationship between untreated depression and total health care costs in 6,257 GHC health maintenance organization (“HMO”) members who were eighteen years of age or older and had a diagnosis of depression made during an outpatient visit between April 1, 1992, and December 31, 1992.⁸¹ Using computerized visit-diagnosis data, pharmacy records, and cost-accounting data from GHC, the researchers compared overall health care costs for primary care patients with recognized depression and overall health care costs for age- and gender-matched patients without depression.⁸² The researchers found that the patients diagnosed with depression had higher annual health care costs (\$4,246 versus \$2,371), and 50% to 75% higher costs for every category of care setting, including the primary care setting, all medical specialties, the medical inpatient setting, and the pharmacy and laboratory settings.⁸³ The researchers concluded not only that the diagnosis of depression was associated with a twofold increase in use of health services⁸⁴ but also

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

⁷⁷ 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.”); DEP’T HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DESIGNING EMPLOYER-SPONSORED MENTAL HEALTH BENEFITS, DHHS Pub. No. SMA-06-4177, 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).

⁷⁸ See *infra* notes 125–144 and accompanying text; see also 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) (“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.”).

⁷⁹ See Gregory E. Simon et al., *Health Care Costs of Primary Care Patients with Recognized Depression*, 52 ARCHIVES GEN. PSYCHIATRY 850, 850 (1995).

⁸⁰ See *id.*

⁸¹ See *id.* at 851.

⁸² See *id.* at 852.

⁸³ See *id.* at 850–52.

⁸⁴ See *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 diag-

that the greater medical utilization exceeded the costs that would be associated with treating the depression.⁸⁵ As part of their conclusion, the researchers recommended that policy decisions regarding the scope of mental health insurance benefits take into account the association between depression and total health care costs.⁸⁶

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.”⁸⁷ The researchers conducted a four-year (1989–1993) prospective study of 2,558 older-than-sixty-five adults in GHC.⁸⁸ 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).⁸⁹ The researchers then compared each patient’s depressive symptoms to data obtained from GHC’s cost accounting system relating to each patient’s total health care costs.⁹⁰ 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.⁹¹ More specifically, the researchers found that patients with significant depression at baseline had higher median costs (\$2,147) during the first year after baseline than patients without depression (\$1,461).⁹² Patients with significant depressive symptoms at baseline also had higher median costs at year four (\$15,423) than patients without depressive symptoms (\$10,152).⁹³ The researchers also found that the increase in the cost of general medical services associated with depression was spread over all components of health care.⁹⁴ 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.⁹⁵ The researchers further found that the increase in the cost of general

nosed as having depression and the comparison group was maintained over 12 months of observation, suggesting a chronic component to utilization differences.

Id.

⁸⁵ See *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.”).

⁸⁶ See Simon et al., *supra* note 79, at 855.

⁸⁷ 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).

⁸⁸ *Id.* at 1618–19.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.* at 1618.

⁹² *Id.*

⁹³ *Id.* at 1620.

⁹⁴ *Id.* at 1618, 1621.

⁹⁵ *Id.* at 1620.

medical services was not accounted for by an increase in specialty mental health care,⁹⁶ and that even after adjusting for differences in age, sex, and severity of chronic medical illness, the increase in health care costs remained significant.⁹⁷ The researchers formally concluded that depressive symptoms in older adults are associated with a significant increase—roughly 50%—in the total cost of general medical services.⁹⁸ The researchers also suggested that mental health insurance benefit disparities might be shortsighted because they ultimately may increase total health care costs.⁹⁹

Similar findings have been shown in other health care delivery settings. In 2009, researchers affiliated with Massachusetts General Hospital and Massachusetts Institute of Technology published the results of a study designed to better understand the interaction between depression and the cost of non-mental health care in eleven chronic comorbid diseases.¹⁰⁰ To that end, the researchers examined the insurance claims of 618,780 patients enrolled in self-insured, private health care plans based primarily in Texas, California, and across the eastern seaboard.¹⁰¹ 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.¹⁰² In each disease cohort, the researchers calculated median annual non-mental health cost for individuals with and without depression.¹⁰³ 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.¹⁰⁴ The per-patient difference in non-mental health costs between non-depressed and depressed patients ranged

⁹⁶ *Id.* at 1618, 1621.

⁹⁷ *Id.* at 1618, 1620–21.

⁹⁸ *Id.* at 1618, 1621.

⁹⁹ *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.

Id.

¹⁰⁰ See Charles A. Welch et al., *Depression and Costs of Health Care*, 50 *PSYCHOSOMATICS* 392, 392 (2009).

¹⁰¹ *Id.* at 393.

¹⁰² *Id.*

¹⁰³ *Id.* at 394.

¹⁰⁴ *Id.*

from \$1,570 in obesity to \$15,240 in congestive heart failure.¹⁰⁵ The ratio of cost between non-depressed and depressed patients ranged from 1.5 in obesity to 2.9 in epilepsy.¹⁰⁶ 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 \$1,410 in epilepsy.¹⁰⁷ Finally, the researchers found that “each of the 11 chronic comorbid diseases was more prevalent in the depressed cohort than in the non-depressed cohort” (with the ratio of prevalence between non-depressed and depressed patients ranging from 1.4 in coronary artery disease and hypertension to 6.8 in obesity).¹⁰⁸

Given this data, the Massachusetts-based researchers formally concluded that, even when controlling for the number of chronic comorbid diseases, depressed patients had significantly higher costs than non-depressed patients in a magnitude consistent across the eleven chronic comorbid diseases.¹⁰⁹ The researchers suggested several potential reasons for their findings, including the possibility that depressed patients engage in self-neglect, including non-compliance with recommended health care.¹¹⁰ 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.¹¹¹ 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.¹¹² 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 comorbid diseases.¹¹³

Similar depression-to-cost findings also have been demonstrated in the public health care program setting. In 2009, researchers at the University of Washington, Columbia University, the National Institute of Mental Health,

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 394–95.

¹⁰⁸ *Id.* at 395.

¹⁰⁹ *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 comorbid 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”).

¹¹⁰ Welch et al., *supra* note 100, at 399.

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

and Green Ribbon Health published their analysis of the health care claims of 14,902 Medicare beneficiaries who were enrolled in a pilot disease management program designed to investigate the association between depression and total health care costs as well as specific components of health care costs.¹¹⁴ The majority of the Medicare beneficiaries studied had diabetes, many had congestive heart failure, and approximately 20% had both diabetes and congestive heart failure.¹¹⁵ The researchers divided the beneficiaries into three mental health status groups: 2,108 beneficiaries who had been diagnosed with depression, 1,081 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.¹¹⁶ The researchers found that the beneficiaries diagnosed with depression incurred approximately \$22,960 in total health care costs over one year, while those without depression incurred costs of approximately \$11,956 over the same year.¹¹⁷ Medicare beneficiaries with possible depression based on depression screening or reported antidepressant use incurred \$14,365 in total annual health care costs.¹¹⁸

The researchers found that the beneficiaries with diagnosed depression spent significantly more in almost all health care cost categories, including home health care, skilled nursing care, outpatient non-mental health care, inpatient non-mental health care, physician services, and durable medical equipment.¹¹⁹ The beneficiaries with diagnosed depression did not, however, spend more money on specialty mental health care compared to the beneficiaries without depression.¹²⁰ Total mental health care costs accounted for less than two percent of total health care costs for the beneficiaries with depression.¹²¹ 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 had both significantly higher health care costs and were not receiving enough mental health care.¹²² The researchers theorized that the higher Medicare copayments that applied to outpatient mental health care (50% at the time of the study, now 45%) compared to outpatient physical health care (20% then and now) posed an obstacle to the receipt of

¹¹⁴ 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*].

¹¹⁵ *Id.* at 507.

¹¹⁶ *Id.* at 508.

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 509.

¹²⁰ *Id.*

¹²¹ *Id.* at 508.

¹²² *Id.* at 509.

needed mental health care.¹²³ The researchers suggested in their conclusion that evidence-based depression care may yield long-term cost savings.¹²⁴

Given the literature showing an association between untreated mental illness and health care cost increases, a number of research groups began to investigate whether treatment of mental illness could produce subsequent decreases in total health care costs. To that end, researchers affiliated with GHC published in 2006 the results of a study investigating the association between depression treatment and health care costs over the subsequent six months.¹²⁵ In their research, the study authors analyzed data obtained from GHC associated with 1,814 patients who met criteria for major depressive episodes and entered treatment.¹²⁶ 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.¹²⁷ After adjusting for baseline differences in the severity of each patient's initial depression and expected health care costs, the study authors found that mean health services costs over the six months following acute-phase treatment were \$2,012 for those achieving remission, \$2,571 for those improved but not remitted, and \$3,094 for those with persistent major depression.¹²⁸ 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.¹²⁹ The authors formally concluded that remission from depression is associated with significantly lower subsequent health care services utilization and health care costs across the full range of mental health and general medical services compared with persistent depression.¹³⁰

Similar findings have been demonstrated in a variety of other health care delivery contexts. In 2008, for example, researchers published the re-

¹²³ *Id.* at 510; see also *supra* note 19 and accompanying text.

¹²⁴ See Unützer et al., *Healthcare Costs*, *supra* note 114, at 510.

¹²⁵ Gregory E. Simon, Rezaul K. Khandker, Laura Ichikawa & Belinda H. Operskalaski, *Recovery from Depression Predicts Lower Health Services Costs*, 67 J. CLINICAL PSYCHIATRY 1226 (2006).

¹²⁶ *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.

¹²⁷ *Id.* at 1226, 1228.

¹²⁸ *Id.* at 1226.

¹²⁹ *Id.*

¹³⁰ *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.

sults of a randomized controlled trial, Improving Mood: Promoting Access to Collaborative Treatment (“IMPACT”), which was designed to investigate the long-term effects on total health care costs of participation in a depression treatment program compared with usual primary care.¹³¹ 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.¹³² 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.¹³³ 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.¹³⁴ The researchers obtained from the trial sites cost accounting data that tracked costs associated with all health care delivered to the patients.¹³⁵

The study authors found that the patients who were assigned to the IMPACT group had lower mean total health care 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 \$3,363 per patient on average during four years.¹³⁶ The IMPACT patients had lower health care costs than the usual care patients in every health care 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.¹³⁷ The researchers formally concluded that, when compared with usual primary care, the IMPACT program is associated with a high probability of lower total health care costs during a four-year period.¹³⁸ The researchers also stated that 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.¹³⁹

¹³¹ See Jürgen Unützer et al., *Long-Term Cost Effects of Collaborative Care for Late-Life Depression*, 14 AM. J. MANAGED CARE 95 (2008).

¹³² *Id.* at 95–96.

¹³³ *Id.*

¹³⁴ *Id.* at 96.

¹³⁵ *Id.*

¹³⁶ *Id.* at 95, 98.

¹³⁷ *Id.* at 98.

¹³⁸ *Id.* at 95.

¹³⁹ *Id.* at 100. For additional information regarding the IMPACT study and the adoption of the IMPACT approach by other health care 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*, HEALTH AFF., Sept. 1999, at 193, 201 (finding that general health care costs and sick days

The studies described above were conducted in populations of patients with traditional mental illnesses, such as depression and dysthymia. Researchers also have investigated the relationship between treatment of other mental illnesses, such as alcohol and drug abuse, and health care costs as well as a number of other variables, including employment, drug and alcohol consumption, and criminal activity. These studies show that treating alcohol and drug abuse can yield significant clinical and economic returns on an employer's or public health care 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.¹⁴⁰ 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.¹⁴¹ 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.¹⁴² The study also demonstrated that the average cost of treatment amounted to \$2,530 for FC addiction care and \$1,138 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 care.¹⁴³ 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.¹⁴⁴

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.").

¹⁴⁰ See 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).

¹⁴¹ See *id.* at 617–18.

¹⁴² See *id.* at 625–26.

¹⁴³ See *id.* at 625.

¹⁴⁴ See *id.* at 609, 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.").

In addition to clinically-oriented studies that use private health plan and public health care program data to show an association between mental illness and total health care 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,¹⁴⁵ the same efficiency concerns are less valid under managed health care.¹⁴⁶ This is especially true for managed mental health care 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.¹⁴⁷ 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.¹⁴⁸ In theory, managed behavioral health carve-out plans eliminate unnecessary utilization at its source and on a case-by-case basis.¹⁴⁹

In one study published in 1998, three researchers tracked access, utilization, and costs of mental health care 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).¹⁵⁰ 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 43% 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.¹⁵¹ The study authors attributed the cost savings

¹⁴⁵ See *supra* note 52 and accompanying text.

¹⁴⁶ See *supra* notes 53–58 and accompanying text.

¹⁴⁷ 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 9, at 190 (discussing behavioral health carve-out plans); Ma & McGuire, *supra* note 57, at 54.

¹⁴⁸ See, e.g., Barry, *Political Evolution*, *supra* note 9, at 190 (noting growth of carve-out plans); Frank et al., *supra* note 47, at 1702 (noting tendency of carve-out plans to reduce spending); Ma & McGuire, *supra* note 57, 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.”).

¹⁴⁹ See, e.g., SURGEON GENERAL REPORT, *supra* note 9, at 423.

¹⁵⁰ See William Goldman, Joyce McCulloch, & Roland Sturm, *Costs and Use of Mental Health Services Before and After Managed Care*, HEALTH AFF., Mar. 1998, at 40, 41.

¹⁵¹ *Id.* at 45.

in part to a decline in inpatient admissions and an increased use of outpatient care.¹⁵² According to the study authors, “The main result is that despite higher initial access to specialty care in the post period and substantially increased benefits, costs for mental health care declined dramatically in the first year and continued to decline slowly in the following five years.”¹⁵³ 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.”¹⁵⁴

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.¹⁵⁵ 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.¹⁵⁶ The economists found a very significant cost reduction after the initiation of the carve-out plan.¹⁵⁷ 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.¹⁵⁸ 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.¹⁵⁹ 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 1995.¹⁶⁰ Overall, the economists found a 50–60% gross reduction in costs and an estimated 30–40% 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.¹⁶¹ The economists formally con-

¹⁵² *Id.* at 46–47.

¹⁵³ *Id.* at 48.

¹⁵⁴ *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 Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88(3) *MILBANK Q.* 404, 414–15 (2010) [hereinafter Barry et al., *Political History*] (“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(2) *J. BEHAV. HEALTH SERVS. & RES.* 203, 210 (1999) (“In contrast to 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.”).

¹⁵⁵ See Ma & McGuire, *supra* note 57, at 54.

¹⁵⁶ See *id.* at 62.

¹⁵⁷ See *id.* at 63.

¹⁵⁸ See *id.*

¹⁵⁹ See *id.*

¹⁶⁰ See *id.*

¹⁶¹ See *id.* at 64–65.

cluded that “by any standard, the data show a very significant cost reduction after the carve-out.”¹⁶²

In a third study published in 2008, three researchers from Harvard University investigated the demand response of mental health services to cost-sharing under managed health care and compared it to the demand response of mental health services to cost-sharing under traditional indemnity (fee-for-service) plans.¹⁶³ 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.¹⁶⁴ The researchers found that the effect of the coinsurance 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.¹⁶⁵ The researchers formally concluded that managed care, not out-of-pocket prices paid by consumers, controls rates of utilization.¹⁶⁶ The researchers also stated in their conclusion that efficiency arguments against mental health parity may not apply to managed care settings.¹⁶⁷

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 in particular health care delivery settings shows that mental health parity implementation has not increased total health care delivery costs. One such setting is the Federal Employees Health Benefits (“FEHB”) Program, the largest employer-sponsored health insurance program in the United States that serves more than eight million federal employees, annuitants, and dependents.¹⁶⁸ In January 2001, the FEHB Program instituted a mental health and substance abuse parity policy in compli-

¹⁶² See *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.”).

¹⁶³ See Lu et al., *Demand Response*, *supra* note 55, at 113.

¹⁶⁴ *Id.* at 114.

¹⁶⁵ *Id.* at 119–20.

¹⁶⁶ *Id.* at 121.

¹⁶⁷ *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.

Id.

¹⁶⁸ 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*].

ance with a parity order issued by President Clinton in July 1999.¹⁶⁹ The parity order required equality between the rates, terms, and conditions (including deductibles, copayments, inpatient day limitations, and outpatient visit limitations) that applied to the FEHB Program's medical and surgical benefits and those that applied to mental health and substance use disorder benefits.¹⁷⁰ At the time of its issuance, one concern associated with the parity order was that the FEHB Program would incur large increases in both mental health service use and federal spending on mental health services.¹⁷¹ The federal Department of Health and Human Services ("HHS") thus commissioned a study to evaluate the effect of the parity order in the FEHB Program on costs as well as other important indicators.¹⁷² The authors of the commissioned study concluded that the cost concerns were unfounded: "When coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs."¹⁷³ 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.¹⁷⁴

The FEHB Program is not alone in its mental health parity implementation cost experiences. Reports indicate that states with mental health parity legislation 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 subsequently experienced either lower costs or extremely modest cost increases (e.g., nineteen cents per member per month) in the first year of implementation.¹⁷⁵ Additional studies report that Maryland and North Carolina exper-

¹⁶⁹ *Id.* at 1; Howard H. Goldman et al., *Behavioral Health Insurance Parity for Federal Employees*, 354 *NEW ENG. J. MED.* 1378, 1379 (2006).

¹⁷⁰ FEHB FINAL REPORT, *supra* note 168, at 1.

¹⁷¹ 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).

¹⁷² See DEP'T HEALTH & HUMAN SERVS., ASSISTANT SEC'Y PLANNING & EVALUATION, GROWTH IN PREMIUMS IN THE FEHBP FROM MENTAL HEALTH PARITY, (May 20, 2005), *available at* <http://aspe.hhs.gov/health/reports/05/mhsamemo.htm>; FEHB FINAL REPORT, *supra* note 168, at 3 (identifying as key research questions: "[d]id FEHB plans incur additional expenses in implementing the parity policy?" and "[h]ow did the parity policy affect cost of [mental health and substance abuse] care to the beneficiary and [the Office of Personnel Management]?").

¹⁷³ Goldman et al., *supra* note 169, at 1378, 1386.

¹⁷⁴ *Id.* at 1385.

¹⁷⁵ See 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) (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

experienced decreased costs following the implementation of mental health parity when such parity coincided with the introduction of managed behavioral health care.¹⁷⁶

In summary, health insurers have offered a number of different reasons for their disparate physical and mental health insurance benefits, including the argument that mental health parity will cause insurers' costs to rise. However, the current health plan literature shows that untreated mental illness is associated with increases in total health care costs and that treatment of mental illness is associated with decreases in total health care costs. In addition, the current mental health economics literature shows that managed behavioral health care significantly reduces—if not eliminates—the problem of moral hazard in the context of mental health care. Finally, recent studies of cost data obtained from health care delivery settings in which mental health parity has been implemented show that mental health parity implementation has at most negligibly increased total health care delivery costs in those settings.¹⁷⁷ The current literature thus does not support insurers' refusal to implement mental health parity based on cost concerns.

III. NEGATIVE IMPLICATIONS OF UNTREATED MENTAL ILLNESS

A. *Private and Social Costs*

Health plans that are exempt from mental health parity law and mandatory mental health and substance use disorder benefits may continue to impose mental health benefit restrictions in an attempt to control perceived moral hazard and adverse selection concerns without recognizing other implications of untreated mental illness, including decreased rates of work productivity as well as increased rates of disability, homelessness, welfare, and crime.¹⁷⁸

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.”).

¹⁷⁶ 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) (summarizing state experiences).

¹⁷⁷ See, e.g., SURGEON GENERAL REPORT, *supra* note 9, at 428–29; Feldman et al., *supra* note 74, at 216.

¹⁷⁸ See, e.g., DEP'T HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DESIGNING EMPLOYER-SPONSORED MENTAL HEALTH BENEFITS 15 (2006) [hereinafter DESIGNING MENTAL HEALTH BENEFITS] (“[T]here are also business costs of untreated mental illness, as evidenced by increased absenteeism, presenteeism, diminished productivity, and increased disability claims costs.”); Kaplan, *supra* note 29, at 331–33 (examining the high rates of absenteeism, lost productivity, unemployment, disability, crime, and homelessness associated with untreated mental illness); National Alliance on Mental Illness, *What is Mental Illness: Mental Illness Facts*, NAMI.ORG, http://www.nami.org/template.cfm?section=about_mental_illness (“Without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives . . .”).

Estimates of lost work productivity associated with mental illness vary greatly, although many studies show a significant association between mental illness and lost productivity.¹⁷⁹ Researchers have shown that U.S. employers incur anywhere from \$20 billion to \$40 billion per year in lost productivity due to employees' mental illness.¹⁸⁰ A number of studies also show that both absenteeism and presenteeism¹⁸¹ are greater among workers with mental illness than among workers without mental illness.¹⁸² For example, one representative study published in 2004 by the American Psychological Association showed that workers with depression are three times more likely to be absent from work than workers without depression.¹⁸³ A second representative study published in 2004 by researchers affiliated with Harvard Medical School investigated the effects of major depression on presenteeism, including moment-in-time work performance decreases.¹⁸⁴ The Harvard researchers studied 105 airline reservation agents and 181 telephone customer service representatives who reported on their work performance at five random moments in time throughout the day over seven consecutive days.¹⁸⁵ The researchers found that seven conditions, including allergies, arthritis, back pain, headaches, high blood pressure, asthma, and major depression occurred in the group of subjects being studied; however, major depression was the only condition that was significantly related to decrements in both task focus and productivity.¹⁸⁶ The researchers found that the effect of depression on task focus and productivity was equivalent to approximately 2.3 days of absenteeism per depressed worker per month and that, if assigned a dollar amount, the workers' losses in productivity exceeded \$300 per month per employee.¹⁸⁷ The researchers concluded that previous studies

¹⁷⁹ See DESIGNING MENTAL HEALTH BENEFITS, *supra* note 178, at 16; see also Walter F. Stewart et al., *Cost of Lost Productive Work Time Among U.S. Workers with Depression*, 289 JAMA 3135, 3135 (2003) ("Evidence consistently indicates that depression has adversely affected work productivity.").

¹⁸⁰ DESIGNING MENTAL HEALTH BENEFITS, *supra* note 178, at 16. Employers in other countries also have reported lost productivity associated with mental illness. See, e.g., Chunling Lu, Richard G. Frank, Yuanli Liu & Jian Shen, *The Impact of Mental Health on Labour Market Outcomes in China*, 12 J. MENTAL HEALTH POLICY & ECON. 157, 157, 163 (2009) (reporting that poor mental health status is disruptive of labour market activities in China).

¹⁸¹ Presenteeism refers to a situation in which an employee is physically present on the job but has decreased productivity due to emotional difficulties. See, e.g., DESIGNING MENTAL HEALTH BENEFITS, *supra* note 178, at 16; Mark Moran, *Depressed Workers on the Job Hurt the Bottom Line*, PSYCHIATRIC NEWS, Nov. 5, 2004, at 5, 5.

¹⁸² DESIGNING MENTAL HEALTH BENEFITS, *supra* note 178, at 16–17.

¹⁸³ *Id.* at 17.

¹⁸⁴ Philip S. Wang et al., *Effects of Major Depression on Moment-in-Time Work Performance*, 161 AM. J. PSYCHIATRY 1885, 1885–91 (2004).

¹⁸⁵ *Id.* at 1886.

¹⁸⁶ *Id.* at 1886–87.

¹⁸⁷ On a base of 225 workdays each year (i.e., a typical 250-day work year minus approximately 25 days of absence for sickness per year among depressed workers with episodes that persist the entire year), this is equivalent to somewhat more than 2 days of lost productivity per month of being depressed ($225/[8 \times 12] = 2.3$). . . . Even with the relatively low salaries of the service workers in this study, the combined

based on days missed from work significantly underestimated the adverse economic effects associated with depression¹⁸⁸ and that productivity losses related to depression appear to exceed the costs of effective treatment.¹⁸⁹ Similarly, HHS reviewed literature on the financial impact of mental disorders in the workplace and concluded that employers' productivity-related costs associated with untreated mental illnesses are significantly greater than employers' cost of providing insurance coverage for such mental illnesses.¹⁹⁰ Additional studies show that treatment of employees' mental illnesses resulting in normalization of symptoms is associated with returns in productivity that approach the productivity of employees who have no history of mental illness.¹⁹¹

Several groups of researchers also have investigated the association between diagnosis of mental illness and increased disability claims.¹⁹² In one illustrative study, researchers affiliated with Harvard Medical School analyzed data from two national surveys to estimate the short-term work disability associated with thirty days of major depression.¹⁹³ The researchers found that workers with depression had between 1.5 and 3.2 more short-term work-disability days in a thirty-day period than workers without depression, and that workers with depression averaged salary-equivalent productivity losses between \$182 and \$395 per worker per month.¹⁹⁴ The researchers also found that the workplace costs associated with major depression could be nearly as large as the direct costs of successful depression treatment, suggesting again that covering mental health treatments might be cost-effective for some employers.¹⁹⁵

Other groups of researchers also have reported a significant association between untreated mental illness and homelessness as well as welfare receipt. Several studies have reported that homeless mothers, for example,

salary-equivalent effect of major depression on absenteeism and lost productivity is greater than \$300 per month.

Id. at 1888.

¹⁸⁸ *Id.* ("Consequently, the estimate of lost productivity related to depression on days at work (2.3 days per month) is considerably greater than the lost productivity found in previous studies from sickness absence (approximately 1 day per month).").

¹⁸⁹ *Id.* at 1885; *see also* Stewart et al., *supra* note 179, at 3135 ("The combined LPT [lost productive time] burden among those with depression and the low level of treatment suggests that there may be cost-effective opportunities for improving depression-related outcomes in the US workforce.").

¹⁹⁰ DESIGNING MENTAL HEALTH BENEFITS, *supra* note 178, at 16–17.

¹⁹¹ Michael F. Hilton et al., *The Association Between Mental Disorders and Productivity in Treated and Untreated Employees*, 51 J. OCCUPATIONAL ENVTL. MED. 996, 996, 1002 (2009).

¹⁹² DESIGNING MENTAL HEALTH BENEFITS, *supra* note 178, at 17–18.

¹⁹³ Ronald C. Kessler et al., *Depression in the Workplace: Effects on Short-Term Disability*, HEALTH AFF., Sept. 1999, at 163, 163–71.

¹⁹⁴ *Id.* at 163, 166–67.

¹⁹⁵ *Id.* at 163, 168 ("Our calculations of the thirty-day salary-equivalent work disability associated with thirty-day major depression suggest that between 45 percent (\$182/\$402) and 98 percent (\$395/\$402) of this treatment cost would be offset by increased work productivity associated with symptom remission.").

have higher rates of major depression and substance use disorders than mothers in the general population.¹⁹⁶ Some studies also have reported that individuals who receive welfare have higher rates of mental illness than individuals in the general population. For example, researchers affiliated with Harvard Medical School and Harvard School of Public Health assessed 216 single mothers receiving Aid to Families with Dependent Children (“AFDC”) in Worcester, Massachusetts, and found a lifetime prevalence of major depressive disorder among the women receiving AFDC (42.8%) that was twice the lifetime prevalence of major depressive disorder in the general population (20.0%).¹⁹⁷ The Harvard researchers also found that the lifetime prevalence of posttraumatic stress disorder (“PTSD”) was three times higher in women receiving AFDC (34.1%) than women in the general population.¹⁹⁸ In a second study designed to determine the prevalence, correlates, and likelihood of treatment for mental and substance use disorders in a population of urban single mothers receiving Temporary Assistance for Needy Families (“TANF”), researchers affiliated with the University of Illinois at Chicago studied 333 TANF recipients nearing the end of their eligibility for cash benefits.¹⁹⁹ The Chicago researchers found that the twelve-month prevalence of major depression in the TANF population (17.4%) was more than twice as high as that found among women in the general population (8.6%); that the prevalence of anxiety disorders in the TANF population (39.0%) was 60% higher than the prevalence of anxiety in the general population (23.4%); that the prevalence of drug use and dependence in the TANF population (5.4%) was five times higher than the prevalence of drug use and dependence in the general population (.7%); and that the prevalence of alcohol abuse and dependence in the TANF population (5.1%) was three times higher than the prevalence of alcohol abuse and dependence in the general population (1.8%).²⁰⁰

Several groups of researchers also have reported significant associations between untreated mental illness and increased rates of criminal activity as well as between the treatment of mental illness and lower rates of recidivism. As part of an annual Canadian Population Health Initiative, the Canadian Institute for Health Information recently reported a higher prevalence of mental illness among incarcerated individuals than among the gen-

¹⁹⁶ See, e.g., Ellen L. Bassuk et al., *Prevalence of Mental Health and Substance Use Disorders Among Homeless and Low-Income Housed Mothers*, 155 AM. J. PSYCHIATRY 1561, 1561 (1998) (reporting a number of studies showing a relationship between mental illness and homelessness).

¹⁹⁷ *Id.* at 1563.

¹⁹⁸ *Id.* at 1562–63.

¹⁹⁹ Judith A. Cook et al., *Prevalence of Psychiatric and Substance Use Disorders Among Single Mothers Nearing Lifetime Welfare Eligibility Limits*, 66 ARCH. GEN. PSYCHIATRY 249, 249–58 (2009).

²⁰⁰ *Id.* at 252, 254.

eral population.²⁰¹ The University of Texas Mental Health Policy Collaborative also recently found that adolescents with mental illness are several times more likely than adolescents without mental illness to be involved with the juvenile justice system.²⁰² Importantly, researchers who have compared mental health treatment records to criminal justice records and probation data have found that mental health treatment is associated with better outcomes for criminal offenders, including lower rates of recidivism.²⁰³ Juvenile offenders who received timely and adequate mental health treatment, for example, have been found to have a lower number and lower severity of subsequent criminal charges.²⁰⁴

In summary, untreated mental illness is associated with decreased rates of work productivity as well as increased rates of disability, homelessness, welfare, and crime. Although the studies discussed above do not show that mental illness causes these problems, the studies do suggest the possibility of significant returns on initial mental health treatment investments from employer and public health and social service programs.

B. Judicial Difficulty in Distinguishing Physical and Mental Illness

Given the disparate insurance benefits associated with physical and mental illness in both the public health care program and private health plan settings, many courts have been asked to decide whether a particular insured's illness is physical or mental.²⁰⁵ The courts have had great difficulty making these classifications, which can lead to inconsistent administration and perverse incentives for patients. The courts have responded by creating a number of common law tests that are designed to distinguish physical and mental illness, including tests that focus on the area of specialization of the treating health care provider, the nature and type of treatment provided to the patient, the origin of the patient's illness, and the patient's symptoms.²⁰⁶ Elsewhere, scholars have reviewed these tests to show how claimants may use advances in structural and functional neuroimaging to push the boundaries of these tests.²⁰⁷ A thorough review of these tests shows that not one pro-

²⁰¹ CANADIAN INST. FOR HEALTH INFO., *IMPROVING THE HEALTH OF CANADIANS 2008: MENTAL HEALTH, DELINQUENCY, AND CRIMINAL ACTIVITY* 29 (2008).

²⁰² UNIV. OF TEXAS MENTAL HEALTH POL'Y ANALYSIS COLLABORATIVE, *THE CONSEQUENCES OF UNTREATED MENTAL ILLNESS IN HOUSTON* 24 (Sept. 2009) [hereinafter *UNTREATED MENTAL ILLNESS*].

²⁰³ *Id.* at 24–25.

²⁰⁴ *Id.*

²⁰⁵ See, e.g., Stacey A. Tovino, *Neuroscience and Health Law: An Integrative Approach?*, 42 *AKRON L. REV.* 469, 478–84 (2009) [hereinafter *Tovino, Neuroscience*] (summarizing litigation).

²⁰⁶ See *id.* (summarizing different common law tests); Tovino, *Scientific Understandings*, *supra* note 1, at 163–67.

²⁰⁷ See *Tovino, Neuroscience*, *supra* note 205, at 478–84; Tovino, *Scientific Understandings*, *supra* note 1, at 163–67.

vides a rational or consistent method of distinguishing physical and mental illness.

The first test focuses on the area of specialization of the treating health care provider. According to this test, a patient who receives treatment from a psychiatrist, psychologist, social worker, or mental health counselor has a mental illness, whereas a patient who receives treatment from a non-psychiatrist physician or other allied health professional has a physical illness.²⁰⁸ One problem with the provider test is that approximately one-half of all mental health care delivered in the United States is delivered solely by general practitioners, primary care physicians, obstetricians-gynecologists, and other physicians who have no specialized training in psychiatry or mental health.²⁰⁹ Indeed, psychiatrists now prescribe only one-third of all psychotropic medications in the United States, with primary care physicians and other medical specialists prescribing the remaining two-thirds.²¹⁰ In addition, some studies report that psychiatric patients see primary care physicians and other non-psychiatrist medical specialists for their psychiatric problems *because of their health plans' mental health benefit disparities*, including the higher cost-sharing that may apply to outpatient visits with mental health care providers.²¹¹ Individuals with mental illness thus are encouraged by their insurers to seek care from professionals who may have little or no training in providing mental health care.

An application of the provider test can lead to inconsistent results. For example, the test can lead to the classification of an individual with major depression and suicidal thoughts who sees a psychiatrist as an individual with a mental illness, but the classification of a second individual with the same depression and suicidal ideation who sees a primary care physician or an emergency room physician (perhaps due to an HMO-imposed constraint relating to referrals to specialists) as an individual with a physical illness.²¹² The two patients have the same diagnosis and the same presenting symptoms, but one may be classified as physically ill and the other may be classified as mentally ill due to differences in their access to primary care and specialty care providers.

A second test focuses on the nature of the treatment provided to the patient. According to this test, a patient has a mental illness if the patient

²⁰⁸ See, e.g., *Blake v. UnionMutual Stock Life Ins. Co.*, No. 87-0543-CIV, 1989 U.S. Dist. LEXIS 16331, at *12 (S.D. Fla. Mar. 10, 1989) (explaining that the patient's postpartum depression was properly considered a mental illness because "she was treated primarily by psychiatrists . . .").

²⁰⁹ See Tovino, *Scientific Understandings*, *supra* note 1, at 166–67 (criticizing the provider test); see also Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5423 (Feb. 2, 2010) ("Currently, approximately half of mental health care is delivered solely by primary care physicians.").

²¹⁰ See, e.g., Barry et al., *Still Unequal*, *supra* note 27, at 134.

²¹¹ Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5423 (Feb. 2, 2010).

²¹² See Tovino, *Scientific Understandings*, *supra* note 1, at 166–67 (criticizing the provider test).

receives traditional mental health treatments such as individual or group mental health counseling, psychoanalysis, electroshock therapy, or psychotropic medication.²¹³ A patient has a physical illness, on the other hand, if the patient receives medical and surgical treatments such as intravenous fluid administration, artificial nutrition, chemotherapy, radiation, or open-heart surgery.²¹⁴ The treatment test focuses solely on the nature and type of treatments provided to the patient, not whether the treatments are required due to a diagnosis that may typically be classified as physical or mental. In *Simons v. Blue Cross*, for example, an insured father sued his insurance company after it denied coverage for additional inpatient days for his dependent teenage daughter, Amy, who had a diagnosis of anorexia nervosa.²¹⁵ Even though anorexia nervosa traditionally has been classified as a mental illness, the court held that Amy's treatments, which included hospitalization for treatment of malnutrition, naso-gastric tube feedings, intravenous fluid administration, and a neurological consultation and evaluation, were physical treatments and that Amy was entitled to comprehensive insurance coverage of those treatments.²¹⁶

The treatment test can also lead to illogical or inconsistent results because it incentivizes waiting until a mental illness becomes a physical problem rather than encouraging early diagnosis and treatment of the mental illness. For example, an individual with major depression who requires stomach-pumping following a drug overdose, or stitches for sliced wrists following a suicide attempt, will be classified as an individual with a physical illness, whereas an individual with major depression and suicidal ideation who seeks counseling in an attempt to prevent a drug overdose or suicide attempt will be classified as an individual with a mental illness.²¹⁷

A third test focuses on the origin of the patient's illness. According to this test, a patient has a physical illness if the patient's illness has an organic, or biological, basis.²¹⁸ One legal problem with this test is that many illnesses traditionally classified as mental, including schizophrenia, bipolar disorder, major depressive disorder, and obsessive-compulsive disorder, already have

²¹³ See, e.g., *Simons v. Blue Cross*, 536 N.Y.S.2d 431, 434 (N.Y. App. Div. 1989) ("The plain, ordinary meaning of 'psychiatric' care is the sort of treatment, such as electroshock therapy and psychotropic medication, rendered to a patient who has been admitted to a psychiatric ward in order to attend to his or psychiatric disorder.").

²¹⁴ *Id.* at 434–35.

²¹⁵ *Id.* at 432.

²¹⁶ *Id.* at 434.

²¹⁷ See, e.g., *id.* at 434–35 ("An attempted suicide, for instance, may have profound psychiatric problems warranting psychotherapy or other psychiatric care but the patient must still be medically treated for the self-inflicted drug overdose or gunshot wound endangering his or her life."). See generally *Tovino, Scientific Understandings*, *supra* note 1, at 165–66 (criticizing the treatment test).

²¹⁸ See, e.g., *Arkansas Blue Cross v. Doe*, 733 S.W.2d 429, 431–32 (Ark. Ct. App. 1987) (deferring to the lower court's finding that bipolar affective disorder has a biological basis).

been found by state legislatures to have a biological basis,²¹⁹ and these legislative findings may be inconsistent with an insurer's view regarding the illnesses that constitute mental illnesses. Moreover, it is possible that attorneys representing insureds could reference almost any neuroimaging study reporting a structural or functional correlate of a mental illness and try to convince a lay judge that the insured's illness has a biological basis.²²⁰ For example, in *Arkansas Blue Cross v. Doe*, an insured father called four psychiatrists and two clinical psychologists to testify that his daughter's bipolar disorder had a biological basis.²²¹ The experts convinced the court that the current scientific evidence overwhelmingly showed that bipolar disorder has physical and biological causes.²²² The court ultimately agreed that the daughter's bipolar disorder was a physical illness, not a mental illness.²²³

The biological basis test is also not ideal because many health conditions have a multifactorial etiology that precludes biology from serving as a singular, distinguishing feature.²²⁴ Some cancers, at least in theory, have a purely biological basis, while others, such as lung cancer, may have been caused or reinforced by smoking or proximity to second-hand smoke. Finally, the test's emphasis on biology could create confusion and inconsistency because insurance companies do not apply a similar biology threshold to physical injuries when determining coverage. If one child pushes another child on the playground and the second child breaks her arm, or if an adult driver suffers whiplash as a result of a motor vehicle accident caused by a second driver who is texting while driving, there is no biological basis for the broken arm or the whiplash injury. The cause in both cases may be classified as social or environmental. Yet, no insurance company would deny

²¹⁹ See, e.g., MASS. GEN. LAWS ch. 175, § 47B(a) (2010) (classifying the following illnesses as biologically-based mental illnesses: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism); NEV. REV. STAT. § 689A.0455(8) (2010) (classifying the following illnesses as biologically-based mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, and obsessive-compulsive disorder).

²²⁰ See, e.g., Tovino, *Neuroscience*, *supra* note 205, at app. 510–17 (summarizing recent neuroscientific investigations of common mental illnesses that identify structural and functional correlates of these illnesses).

²²¹ *Arkansas Blue Cross*, 733 S.W.2d at 431.

²²² *Id.* (quoting Dr. Thomas Harris, the son's treating psychiatrist, as stating that, "The medical research is now, in my opinion, overwhelming in that regard. . . . This illness . . . manifests some behavioral or emotional disturbances, but the causes of those manifestations are physical and biological in nature.").

²²³ *Id.* at 432.

²²⁴ See Tovino, *Scientific Understandings*, *supra* note 1, at 101, 121 (outlining a multifactorial model for postpartum illness that gives weight to hormonal, genetic, evolutionary, psychosocial, sociocultural, and other biological and environmental factors).

treatment for the child's broken arm or the adult's whiplash injury due to a lack of basis in biology.²²⁵

A final test focuses on the patient's symptoms. According to this test, a patient has a mental illness if the patient's symptoms are behavioral, such as mood swings, delusions, hallucinations, aberrant behavior, or lying.²²⁶ Courts that follow this test reason that most laymen classify illnesses based on their symptoms, not whether the illness has a basis in biology.²²⁷ The problem with the symptom test is that it does not always lead to the most consistent, rational results either. The first readily-observable symptoms of a severe eating disorder may be malnutrition and dehydration, thus leading to classification of a particular individual's eating disorder as a physical illness, although the public typically views eating disorders as mental illnesses. Likewise, the first symptoms of an individual who has Alzheimer's disease, Parkinson's disease, or has suffered a stroke may be aberrant behavior or aberrant movements, although Alzheimer's disease, Parkinson's disease, stroke, and other neurological conditions frequently are classified as physical illnesses, not mental illnesses.

In summary, courts have attempted to distinguish physical and mental illnesses based on a number of different tests that inquire into the area of specialization of the treating health care provider, the nature and type of treatment, the origin of the illness, and the symptoms of the illness. Not one of these tests provides a rational, consistent method of distinguishing physical and mental illness. Public health programs and private health plans should not be permitted to tie health insurance benefits to artificial distinctions such as these.

IV. THE INCOMPLETE DEVELOPMENT OF FEDERAL MENTAL HEALTH PARITY LAW

A. *The Mental Health Parity Act of 1996*

The federal government took its first step towards establishing mental health parity on September 26, 1996, when President Bill Clinton signed the

²²⁵ See, e.g., Barry, *Political Evolution*, *supra* note 9, at 189 (reporting Congressional testimony that biological origin is not the only important factor in determining whether a health insurance company should cover a particular health condition).

²²⁶ See, e.g., *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990) ("Robert C. Brewer's disease manifested itself in terms of mood swings and aberrant behavior. Regardless of the cause of his disorder, it is abundantly clear that he suffered from what laypersons would consider to be a 'mental illness.' Consequently, Lincoln National properly limited its coverage under both policies."); *Equitable Life Assurance Soc'y v. Berry*, 212 Cal. App. 3d 832, 839-40 (Cal. Ct. App. 1989) (classifying an individual's manic-depressive illness as a mental illness characterized by the individual's changing moods, delusions, and hallucinations).

²²⁷ See, e.g., *Brewer*, 921 F.2d at 154.

Mental Health Parity Act (“MHPA”) into law.²²⁸ As discussed in more detail below, MHPA regulates the lifetime and annual spending limits that covered group health plans may apply to mental health benefits if such plans already offer both physical health and mental health benefits.²²⁹ As originally enacted, MHPA only regulated insured and self-insured group health plans of non-small employers, defined as those employers that employ an average of 51 or more employees.²³⁰ MHPA thus did not apply to the group health plans of small employers,²³¹ 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.²³² 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 plan of at least one percent.²³³ 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.²³⁴

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 group health plan to actually offer or provide any mental health benefits.²³⁵ As originally enacted, MHPA also was not a comprehensive parity

²²⁸ See MHPA, Pub. L. No. 104-204, secs. 701–03, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)).

²²⁹ See *id.* sec. 702, § 712(a)(1), (2).

²³⁰ See *id.* sec. 702, § 712(a)(1), (2) (applying in each case to “a group health plan (or health insurance coverage offered in connection with such a plan . . .)”).

²³¹ See *id.* sec. 702, § 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 employ at least two employees on the first day of the plan year).

²³² See, e.g., 42 U.S.C. § 300gg-21(a)(2)(A) (2006 & Supp. IV 2010) (permitting sponsors of individual or group health plans to opt out of particular federal requirements); 45 C.F.R. § 146.180(a)(1)(v) (2009) (permitting sponsors of non-federal governmental health plans to opt out of certain federal mental health parity requirements); Barry et al., *Political History*, *supra* note 154, at 407 (explaining that MHPAEA does not apply to Medicaid non-managed care plans); Memorandum from Steve Larsen, Dir. Oversight, Dep’t Health & Human Servs., 2 (Sept. 21, 2010) [hereinafter Larsen Memo] (discussing the ability of non-federal governmental plans to opt out of federal mental health parity law and the survival of such ability post-ACA: “Provisions subject to opt-out for plan years beginning on or after 9/23/10 [include] . . . parity in the application of certain limits to mental health benefits (including requirements of the Mental Health Parity and Addiction Equity Act)”; Letter from Cindy Mann, Dep’t Health & Human Servs., Ctrs. Medicare & Medicaid Servs., to State Health Officials, 2 (Nov. 4, 2009) (“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.”).

²³³ MHPA sec. 702, § 712(c)(2).

²³⁴ Barry, *Political Evolution*, *supra* note 9, at 187.

²³⁵ See MHPA sec. 702, § 712(b)(1).

law because it neither protected individuals with substance use disorders²³⁶ nor required parity between physical and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations.²³⁷

As originally enacted, MHPA regulates the lifetime and annual spending limits that covered group health plans may apply to mental health benefits if such plans already offer both physical health and mental health benefits.²³⁸ More specifically, if a covered group health plan does not impose an aggregate lifetime or annual limit on substantially all physical health benefits, the plan may not impose an aggregate lifetime or annual limit on offered mental health benefits.²³⁹ If a covered group health plan does impose an aggregate lifetime or annual limit on substantially all physical health benefits, the plan shall either apply the applicable limit to both physical health and mental health benefits and not distinguish in the application of such limit between the two benefit sets, or, the plan shall not impose any aggregate lifetime or annual limit on mental health benefits that is less than the applicable lifetime or annual limit imposed on physical health benefits.²⁴⁰ MHPA thus would prohibit a covered group health plan from imposing a \$20,000 annual cap or a \$100,000 lifetime cap on mental health care if the plan had no annual or lifetime caps for physical health care or if the plan had higher caps, such as a \$50,000 annual cap or a \$500,000 lifetime cap, for physical health care.

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 (“MHPAEA”).²⁴¹ As discussed in more detail below, MHPAEA built on MHPA by imposing comprehensive parity

²³⁶ See *id.* sec. 702, § 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.”).

²³⁷ See *id.* sec. 702, § 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 . . .”).

²³⁸ See *id.* sec. 702, § 712(a)(1), (2).

²³⁹ See *id.* sec. 702, § 712(a)(1)(A) (no aggregate lifetime limits); *id.* sec. 702, § 712(a)(2)(A) (no annual limits).

²⁴⁰ See *id.* sec. 702, § 712(a)(1)(B) (aggregate lifetime limits); *id.* sec. 702, § 712(a)(2)(B) (annual limits).

²⁴¹ See MHPAEA, Pub. L. No. 110-343, secs. 511–12, 122 Stat. 3765, 3881–93 (codified as amended at 29 U.S.C. § 1185a (2006 & Supp. IV 2010) and 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)).

requirements on covered group health plans. In particular, MHPAEA mandated financial requirements (including deductibles, copayments, coinsurance and other out-of-pocket expenses)²⁴² and treatment limitations (including inpatient day and outpatient visit limitations)²⁴³ 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.²⁴⁴

As originally enacted, MHPAEA (like MHPA) only regulated insured and self-insured group health plans of non-small employers, defined as those employers that employ an average of fifty-one or more employees.²⁴⁵ 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.²⁴⁶ 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.²⁴⁷ 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.²⁴⁸ 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.²⁴⁹ MHPAEA required that determinations of exemption-qualifying cost increases be made and certified in writing by a qualified and licensed actuary who in good standing belongs to the American Academy of Actuaries.²⁵⁰

²⁴² See *id.* sec. 512(a)(1), § 712(a)(3)(B)(i) (including within the definition of “financial requirements” deductibles, copayments, coinsurance, and out-of-pocket expenses).

²⁴³ See *id.* sec. 512(a)(1), § 712(a)(3)(B)(iii) (including within the definition of “treatment limitations” limits on the frequency of treatment, number of visits, days of coverage, and other similar limits on the scope or duration of treatment).

²⁴⁴ See *id.* sec. 512(a)(1), § 712(a)(3)(A) (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).

²⁴⁵ *Id.* sec. 512(c)(3), § 9812(c)(1).

²⁴⁶ See *supra* note 232 and accompanying text.

²⁴⁷ See MHPAEA sec. 512(a)(1), § 712(a)(3)(A) (regulating only those group health plans that offer both physical health and mental health benefits).

²⁴⁸ See *id.* sec. 512(a)(3), § 712(c)(2)(A) (establishing new cost exemption provisions).

²⁴⁹ *Id.* sec. 512(a)(3), § 712(c)(2)(B).

²⁵⁰ *Id.* sec. 512(a)(3), § 712(c)(2)(C).

Notwithstanding these limitations and exemptions, MHPAEA built on MHPA by protecting individuals with substance use disorders²⁵¹ and by imposing comprehensive parity requirements on covered group health plans. In particular, MHPAEA required financial requirements (including deductibles, copayments, coinsurance and other out-of-pocket expenses)²⁵² and treatment limitations (including inpatient day and outpatient visit limitations)²⁵³ 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.²⁵⁴ On February 2, 2010, the Departments of Treasury, Labor, and Health and Human Services co-released an interim final rule implementing MHPAEA's requirements.²⁵⁵ 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 benefits²⁵⁶ 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.²⁵⁷

C. The Affordable Care Act of 2010

Two years after President Bush signed MHPAEA into law, President Obama further expanded mental health parity law by signing into law the

²⁵¹ See *id.* sec. 512(a)(1), § 712(a)(3)(A) (regulating the financial requirements and treatment limitations that are applied to both mental health and substance use disorder benefits); *id.* sec. 512(a)(4), § 712(e)(5) (adding a new definition of "substance use disorder benefits").

²⁵² *Id.* sec. 512(a)(1), § 712(a)(3)(B)(i) (including within the definition of "financial requirements" deductibles, copayments, coinsurance, and out-of-pocket expenses).

²⁵³ *Id.* sec. 512(a)(1), § 712(a)(3)(B)(iii) (including within the definition of "treatment limitations" limits on the frequency of treatment, number of visits, days of coverage, and other similar limits on the scope or duration of treatment).

²⁵⁴ *Id.* sec. 512(a)(1), § 712(a)(3)(A) (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).

²⁵⁵ 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).

²⁵⁶ 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).

²⁵⁷ 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).

health care reform bill, formally known as the Patient Protection and Affordable Care Act of 2010 (“PPACA”) as reconciled by the Health Care and Education Reconciliation Act (“HCERA”) (as consolidated, the Affordable Care Act (“ACA”)).²⁵⁸ Perhaps best known for its controversial (and constitutionally challenged) individual health insurance mandate,²⁵⁹ ACA has buried deep within it several provisions that relate to mental health insurance benefits. If upheld,²⁶⁰ these provisions will expand both mental health parity law and mandatory mental health and substance use disorder benefits to additional, but not all, groups of individuals with public and private health insurance.

A first provision within ACA states: “Section 2726 of the Public Health Service Act [(“PHSA”)] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.”²⁶¹ 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.²⁶² 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, 2014.²⁶³ A second provision buried within ACA makes conforming and technical changes to PHSA section 2726 to clarify the expansion of MHPA and MHPAEA to individual health insurance coverage.²⁶⁴ As a result of these two provisions, many health insurance plans that were previously exempt from MHPA and MHPAEA now are prohibited from offering inferior mental health insurance benefits, including through higher deductibles, copayments, and coinsurance rates, as well as lower inpatient day and outpatient visit limitations.

A third provision in ACA prevents group health plans and health insurance issuers offering group or individual health insurance coverage from

²⁵⁸ ACA, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010).

²⁵⁹ ACA sec. 1501(b), § 5000A(a) (“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.”).

²⁶⁰ See *supra* note 64.

²⁶¹ ACA sec. 1311(j) (entitled, “Applicability of Mental Health Parity”).

²⁶² 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010) (entitled “Parity in Mental Health and Substance Use Disorder Benefits”).

²⁶³ ACA sec. 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 MHPAEA, Pub. L. No. 110-343, sec. 512(a)(1), § 712(a)(3)(A), 122 Stat. 3756, 3881 (codified at 29 U.S.C. § 1185a) (making its provisions applicable to “group health plans or health insurance coverage offered in connection with such a plan”) with 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010) (making its provisions applicable to a “group health plan or a health insurance issuer offering group or individual health insurance”).

²⁶⁴ ACA sec. 1563(c)(4) (identifying the conforming and technical changes that will be made to former 42 U.S.C. 300gg-5 which has since been transferred to 42 U.S.C. § 300gg-26 (2006 & Supp. IV 2010)).

establishing any lifetime as well as certain annual limits on the dollar value of essential health benefits for any participant or beneficiary.²⁶⁵ 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,²⁶⁶ mental health and substance use disorder benefits, including behavioral health treatments, are considered essential health benefits²⁶⁷ 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.²⁶⁸ Now, ACA prohibits all lifetime as well as most annual limits.²⁶⁹

Perhaps most importantly, a final 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 essential health benefits package required under section 1302 of ACA.²⁷⁰ Under section 1301 of ACA, qualified health plans that will be offered on the new ACA-created health insurance exchanges also must provide the essential health benefits package described in section 1302 of ACA.²⁷¹ And, under section 2001 of ACA, Medicaid benchmark plans and benchmark-equivalent plans also must provide the essential health benefits

²⁶⁵ ACA sec. 1001, *as amended* by sec. 10101(a), § 2711(a)(1). 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. 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: (1) \$750,000 for a plan year or policy year starting on or after September 23, 2010 but before September 23, 2011; (2) \$1.25 million for a plan year or policy year starting on or after September 23, 2011 but before September 23, 2012; or (3) \$2 million for a plan year or policy year starting on or after September 23, 2012 but before January 1, 2014. ACA prohibits annual limits on essential benefits beginning January 1, 2014. *See id.* sec. 1001, *as amended* by sec. 10101(a), § 2711(a)(2) (“With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary.”); 75 Fed. Reg. 37188, 37229–30 (June 28, 2010) (adding new lifetime and annual limit regulations at 29 C.F.R. § 2590.715-2711(a)–(d)). *See generally* *Lifetime & Annual Limits*, HEALTHCARE.GOV, Sept. 23, 2010, <http://www.healthcare.gov/law/features/costs/limits/index.html> (explaining the new lifetime and annual limit prohibitions and restrictions).

²⁶⁶ ACA sec. 1001, *as amended* by sec. 10101(a), § 2711(b).

²⁶⁷ *Id.* sec. 1302(b)(1)(E) (including mental health and substance use disorder services, including behavioral health treatment, within the definition of essential health benefits).

²⁶⁸ *See supra* notes 226–228 and accompanying text.

²⁶⁹ *See supra* note 265.

²⁷⁰ ACA sec. 1201, § 2707(a).

²⁷¹ *Id.* sec. 1301(a)(1)(B).

package described in section 1302 of ACA.²⁷² Under the thrice-referenced section 1302 of ACA, essential health benefits include “mental health and substance use disorder services, including behavioral health treatment[s].”²⁷³ Read together, these three provisions are quite significant. Federal law for the first time is mandating mental health and substance use disorder benefits in certain plan settings; that is, the exchange-offered qualified health plan, the non-exchange individual health plan, the non-exchange small group health plan, the Medicaid benchmark plan, the benchmark-equivalent plan, and the Medicaid state plan settings.²⁷⁴

Under regulations co-published by the Departments of Treasury, Labor, and Health and Human Services on June 17, 2010, the Departments clarified, however, that the essential health benefit requirement does not apply to grandfathered health plans.²⁷⁵ A grandfathered health plan is a group health plan or health insurance issuer that was in effect on March 23, 2010, the day President Obama signed PPACA into law.²⁷⁶ 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.²⁷⁷ Situations that will not cause a grandfathered plan to lose grandfathered status include: (1) 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 some-

²⁷² *Id.* sec. 2001(c)(3), § 1937(b)(6).

²⁷³ *Id.* sec. 1302(b)(1)(E) (“essential health benefits . . . shall include . . . [m]ental health and substance use disorder services, including behavioral health treatment”); *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.”).

²⁷⁴ See ACA sec. 1302(b)(1)(E); see also *Essential Health Benefits*, *supra* note 34 (“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”).

²⁷⁵ 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.”)); DEP’T LABOR, EMP. BENEFITS SEC. ADMIN., APPLICATION OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS ACT TO GRANDFATHERED PLANS I (June 17, 2010) [hereinafter DEP’T LABOR, GRANDFATHERED PLANS] (explaining that ACA’s essential benefit package requirement is not applicable to grandfathered plans).

²⁷⁶ 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”).

²⁷⁷ *Id.* at 34541 (defining grandfathered plans and identifying the ways in which grandfathered plans can lose grandfathered status, turning them into non-grandfathered plans).

one since March 23, 2010; (2) 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; (3) the enrollment of newly hired employees and the enrollment of existing employees eligible for new enrollment after March 23, 2010;²⁷⁸ and (4) entering into a new policy, certificate, or contract of insurance (that is, changing insurance carriers) after March 23, 2010.²⁷⁹ Activities that will cause a grandfathered plan to lose grandfathered status include: (1) the elimination of all or substantially all benefits to diagnose or treat a particular condition; (2) any increase in a percentage cost-sharing requirement; (3) certain increases in fixed-amount cost-sharing requirements, including deductibles and out-of-pocket limits but not copayments; (4) certain increases in fixed-amount copayments; (5) certain decreases in contribution rates by employers and employee organizations; and (6) certain changes in annual limits.²⁸⁰

Understanding the distinction between grandfathered and non-grandfathered plans is the key to understanding the application of ACA's health insurance reforms, including its mandatory mental health and substance use disorder benefits provision. Grandfathered health plans are exempt from the vast majority of new insurance reforms required by ACA,²⁸¹ 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

²⁷⁸ *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), § 2590.715–1251(a)(4) (addition of new family members), and § 2590.715–1251(b)(1) (addition of newly hired or newly enrolled employees)). *See generally* BERNADETTE FERNANDEZ, CONGRESSIONAL RESEARCH SERVICE, GRANDFATHERED HEALTH PLANS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) 1 (Apr. 27, 2010).

Current 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.

Id.

²⁷⁹ Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 70144, 70121 (Nov. 17, 2010) (amending 29 C.F.R. § 2950.715–1251(a)(1)(i) to state: “[S]ubject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a new contract with a new issuer or a new policy is issued with an existing insurer).”).

²⁸⁰ 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, 34564–65 (June 17, 2010) (adding 29 C.F.R. § 2590.715–1251(g)(1), which lists the changes that will cause cessation of grandfathered status).

²⁸¹ *See, e.g., id.* at 34540 (explaining that ACA provides that certain group health plans and health insurance coverage existing as of March 23, 2010, are subject only to certain provisions of ACA); FERNANDEZ, *supra* note 278, at 1 (“Grandfathered health plans are exempt from the vast majority of new insurance reforms under PPACA.”).

offer health insurance coverage in the individual and small group markets to ensure that such coverage includes the essential health benefits package required under section 1302(a) of ACA.²⁸² 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,²⁸³ as well as state law, which may or may not contain a mandated mental health and substance use disorder benefit.²⁸⁴ Grandfathered health plans are not the only health plans that are exempt from the essential health benefits requirement. Large group health plans not offered on a health insurance exchange, self-insured ERISA plans, and ERISA-governed multiemployer welfare arrangements also are exempt from the essential health benefits requirement.²⁸⁵

In summary, many public health care program beneficiaries and private health plan members will not have a federal legal right to mental health parity and/or mandatory mental health and substance use disorder benefits even after the full implementation of health care reform. In order to expand mental health parity and mandatory mental health and substance use disorder benefits to all individuals with public and private health insurance, certain federal statutory and regulatory provisions should be revised.

²⁸² See ACA, Pub. L. No. 111-148, 124 Stat. 119, sec. 1201, § 2707(a) (2010), as amended by Pub. L. No. 111-152, 124 Stat. 1029 § 1201 (2010) (“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. 34538, 34559 (June 17, 2010) (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 . . . [section] 2707 . . . do not apply to grandfathered health plans.”)); DEP’T LABOR, GRANDFATHERED PLANS, *supra* note 275 (ACA’s essential benefit package requirement does not apply to grandfathered plans).

²⁸³ See 29 U.S.C. § 1185a(b)(1) (2009) (“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. § 300gg-26(b)(1) (2006 & Supp. IV 2010) (“Nothing in this section shall be construed as requiring a group health plan or a health insurance issuer offering group or individual health insurance coverage to provide any mental health or substance use disorder benefits”).

²⁸⁴ See, e.g., Tovino, *Reforming*, *supra* note 2 (reviewing the patchwork of state mental health parity law).

²⁸⁵ See, e.g., Sara Rosenbaum, Joel Teitelbaum & Katherine Hayes, *The Essential Health Benefits Provisions of the Affordable Care Act: Implications for People with Disabilities*, 3 COMMW. FUND 1, 3 (Mar. 24, 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.”).

V. REFORMING FEDERAL MENTAL HEALTH INSURANCE LAW

A. *The Medicare Program*

The Medicare Program covers approximately forty-five million people, including thirty-eight million individuals age sixty-five or older and seven million individuals with disabilities.²⁸⁶ Medicare is the nation's largest health insurer and processes more than one billion dollars in health care claims each year.²⁸⁷ Approximately twenty-seven percent of Medicare beneficiaries have some type of mental impairment, which means that up to 12.5 million beneficiaries could be affected by Medicare Program mental health benefit disparities.²⁸⁸

As previously discussed,²⁸⁹ the Medicare Program provides the following two-sentence federal regulation codified at 42 C.F.R. § 409.62, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."²⁹⁰ HHS should either: (1) delete 42 C.F.R. § 409.62 in its entirety; or, (2) retain 42 C.F.R. § 409.62, delete the second sentence of the regulation, and revise the first sentence of the regulation to read: "There is no lifetime maximum on inpatient psychiatric hospital services available to any beneficiary."

Through a statute codified at 42 U.S.C. § 13951(c), as amended by the Medicare Improvements for Patients and Providers Act of 2008 ("MIPPA"), the Medicare Program imposes a 45% beneficiary coinsurance on most outpatient mental health services, including individual, family, and group psychotherapy services, instead of the 20% beneficiary coinsurance traditionally applied to physical health outpatient services.²⁹¹ Congress should revise 42 U.S.C. § 13951(c) to phase out the disparate coinsurance amounts that apply to outpatient mental health services by the end of 2011, rather than the cur-

²⁸⁶ Juliette Cubanski, *Medicare 101*, ALLIANCE FOR HEALTH REFORM AND THE KAISER FAMILY FOUNDATION (Mar. 16, 2009), at 6.

²⁸⁷ DEP'T HEALTH & HUMAN SERVS., HHS: WHAT WE DO (2010); DEP'T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., PREDICTIVE MODELING SOFTWARE FOR MEDICARE FEE FOR SRV. (FFS) CLAIMS, SOLICITATION NUMBER: RFP-CMS-2010-0056 (2010) ("The Medicare Fee-for-Service (FFS) program consists of a number of payment systems, with a network of contractors that process over 1.2 billion claims each year, submitted by more than 1 million health care providers such as hospitals, physicians, skilled nursing facilities, hospice facilities, home health agencies, National Council for Prescription Drug Programs (NCPDP) claims from suppliers and labs, ambulance companies, and durable medical equipment (DME) suppliers.").

²⁸⁸ See HENRY J. KAISER FAMILY FOUNDATION, MEDICARE & MEDICAID STATISTICS 25 (2004) [hereinafter KAISER STATISTICS].

²⁸⁹ See *supra* Part I.A.

²⁹⁰ See 42 C.F.R. § 409.62 (2010).

²⁹¹ See 42 U.S.C. § 13951(c) (2006 & Supp. IV 2010).

rently imposed year of 2014.²⁹² More specifically, Congress should: (1) delete current 42 U.S.C. § 1395l(c)(1)(C), (D), and (E); and (2) revise 42 U.S.C. § 1395l(c)(1)(A) and (B) to read as follows:

(c)(1) Notwithstanding any other provision of this part, with respect to expenses incurred in a calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b)—

(A) for expenses incurred in 2011, only 68 3/4 percent of such expenses; and

(B) for expenses incurred in 2012 or any subsequent calendar year, 100 percent of such expenses.

B. *The Medicaid Program*

The Medicaid Program covers more than sixty million low-income Americans, including 29.4 million children, 15.2 million adults, 8.3 million people with disabilities, and 6.1 million seniors.²⁹³ Federal and state expenditures on Medicaid exceed 300 billion dollars annually, and Medicaid is responsible for one out of every five dollars spent on health care in the United States.²⁹⁴ If upheld, the health care reform bill would expand the Medicaid Program to cover an additional 17.1 million Americans.²⁹⁵

Like the Medicare Program, the Medicaid Program also has limited support for individuals who require mental health care in certain inpatient psychiatric settings. Through a regulation codified at 42 C.F.R. § 435.1009(a)(2), Medicaid provides that “[Federal financial participation] is not available in expenditures for services provided to— (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.”²⁹⁶ HHS should either: (1) delete 42 C.F.R. § 435.1009(a)(2) in its entirety; or (2) retain 42 C.F.R. § 435.1009(a)(2) but revise the regulation to read: “FFP is available in expenditures for services provided to— (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.”

²⁹² *Id.*

²⁹³ See, e.g., *Covering the Uninsured in Medicaid*, FAMILIES USA 1 (2009) (providing Medicaid statistics).

²⁹⁴ KAISER STATISTICS, *supra* note 288, at 8.

²⁹⁵ See, e.g., Kaiser Family Foundation, *Expanding Medicaid: Coverage for Low-Income Adults*, FOCUS ON HEALTH REFORM (Feb. 2010), at 1.

²⁹⁶ See 42 C.F.R. § 435.1009(a)(2) (2010).

C. Self-Funded, Non-Federal Governmental Health Plans

Through a federal law codified at 42 U.S.C. § 300gg-21(a) and an implementing regulation codified at 45 C.F.R. § 146.180(a)(1)(v), Congress and HHS allow sponsors of self-funded non-federal governmental health plans to opt out of federal mental health parity.²⁹⁷ The regulation, the more succinct of the two authorities, currently provides that, “A sponsor of a non-Federal governmental plan may elect to exempt its plan, to the extent that the plan is not provided through health insurance coverage, (that is, it is self-funded), from any or all of the following requirements: . . . (v) Parity in the application of certain limits to mental health benefits”²⁹⁸ On September 21, 2010, HHS clarified that self-funded non-federal governmental plans, including state and local government health plans, may continue to opt out of federal mental health parity law even post-ACA.²⁹⁹ As of October 7, 2010, the sponsors of approximately 550 state and local governmental health plans across the United States, including the health plans of the states of Alabama, Alaska, Kentucky, Louisiana, Montana, and North Carolina, have opted out of complying with federal mental health parity law.³⁰⁰ The result is that hundreds of thousands of state and local government employees are subject to inferior mental health insurance benefits.³⁰¹

Congress should revise 42 U.S.C. § 300gg-21 and 45 C.F.R. § 146.180(a)(1)(v) to remove the ability of sponsors of self-insured non-federal governmental health plans to opt out of complying with mental health parity law. More specifically, Congress should delete subparagraph (v) of 45 C.F.R. § 146.180(a)(1) (“Parity in the application of certain limits to mental health benefits . . .”). Congress should also amend 42 U.S.C. § 300gg-21 by adding a new subparagraph at 42 U.S.C. § 300gg-21(a)(2)(F) that would provide: “The election described in subparagraph (A) shall not be available

²⁹⁷ See, e.g., 42 U.S.C. § 300gg-21(a)(2)(A) (2006 & Supp. IV 2010).

Except as provided in subparagraph (D) or (E), if the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2 otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

Id. See also 45 C.F.R. § 146.180(a)(1)(v) (2010).

²⁹⁸ 45 C.F.R. § 146.180(a)(1)(v) (2010).

²⁹⁹ Larsen Memo, *supra* note 232 (discussing the ability of self-funded, non-federal governmental plans to opt out of federal mental health parity law and the survival of such ability post-ACA: “Provisions subject to opt-out for plan years beginning on or after 9/23/10 [include] . . . Parity in the application of certain limits to mental health benefits (including requirements of the Mental Health Parity and Addiction Equity Act)”).

³⁰⁰ DEP’T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., HIPAA OPT-OUT ELECTIONS FOR SELF-FUNDED, NON-FEDERAL GOVERNMENTAL PLANS, http://ccio.cms.gov/resources/files/hipaa_opt_outs_as_of_2011_7_29.pdf (last updated July 29, 2011).

³⁰¹ See *id.*

with respect to parity in the application of certain limits to mental health benefits.”

D. *Small Group Health Plans*

Federal mental health parity law currently does not apply to small group health plans. More specifically, Congress maintains small employer exemptions at 29 U.S.C. § 1185a(c)(1) and 42 U.S.C. § 300gg-26(c)(1) that provide that federal mental health parity law “shall not apply to any group health plan and a health insurance issuer offering group or individual health insurance coverage for any plan year of a small employer”³⁰² Small employers are defined as employers who employ an average of not more than fifty employees.³⁰³ Congress should delete the small employer exemptions codified at 29 U.S.C. § 1185a(c)(1) and 42 U.S.C. § 300gg-26(c)(1).

E. *Grandfathered Health Plans and Large Group Health Plans*

Under ACA, “mental health and substance use disorder services, including behavioral health treatment[s],” must be part of the essential benefit package offered by exchange-offered qualified health plans, non-exchange individual health plans, non-exchange small group health plans, Medicaid state plans, Medicaid benchmark plans, and benchmark-equivalent plans.³⁰⁴ As discussed above,³⁰⁵ grandfathered health plans, on the other hand, are not required to offer the essential benefit package, including mental health and substance use disorder benefits.³⁰⁶ The federal government estimates that approximately 133 million Americans obtain health insurance through large

³⁰² See, e.g., 29 U.S.C. § 1185a(c)(1) (2006); 42 U.S.C. § 300gg-26(c)(1) (2006).

³⁰³ 42 U.S.C. § 300gg-91(e)(4) (2006).

³⁰⁴ See ACA, Pub. L. No. 111-148, sec. 1302(b)(1)(E), 124 Stat. 119 (2010), *as amended* by Pub. L. No. 111-152, 124 Stat. 1029 (2010) (“essential health benefits . . . shall include . . . [m]ental health and substance use disorder services, including behavioral health treatment”); *id.* sec. 1201, § 2707(a) (“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.”).

³⁰⁵ See *supra* notes 275–285 and accompanying text.

³⁰⁶ 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 (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 . . . [section] 2707 . . . do not apply to grandfathered health plans.”)); DEP’T LABOR, GRANDFATHERED PLANS, *supra* note 275 (explaining that ACA’s essential benefit package requirement is not applicable to grandfathered plans).

employers that have grandfathered group health plans,³⁰⁷ and the government further estimates that most—three-quarters—of these large grandfathered health plans will not lose their grandfathered status over the next several years.³⁰⁸ The government also estimates that approximately forty-three million Americans obtain health insurance through small employers that also have grandfathered group health plans, but due to the frequency with which small plans make changes to cost sharing, employer contributions, and other plan features that could cause loss of grandfathered status, up to two-thirds of these plans could lose their grandfathered status over the next several years.³⁰⁹ Finally, the government estimates that approximately seventeen million Americans purchase their health insurance through the individual health insurance market, where substantial changes in coverage are, and thus loss of grandfathered status will be, common.³¹⁰

Because most (or approximately three-quarters) of large grandfathered group health plans, some (or approximately one-third) of small grandfathered group health plans, and a smaller number of grandfathered individual health plans will not lose their grandfathered health status for some time, an estimated 100-plus million Americans will remain in grandfathered health plans that are not required to provide essential health benefits, including mental health and substance use disorder benefits, due to three parallel regulations implementing ACA.³¹¹ One such regulation, codified at 45 C.F.R. § 147.140(c)(1), provides in relevant part: “[T]he provisions of PHS Act sections 2701, 2702, 2703, 2705, 2706, 2707, 2709[,] 2713, 2715A, 2716, 2719, and 2719A, as added or amended by the Patient Protection and Affordable Care Act, do not apply to grandfathered health plans.”³¹² The Departments of Treasury, Labor, and Health and Human Services should amend their three parallel regulations³¹³ to remove the reference to section 2707 of the Public Health Service Act.³¹⁴ The result would be that health plans must provide essential health benefits, including mental health and substance use disorder benefits.

³⁰⁷ *Keeping the Health Plan You Have: The Affordable Care Act and “Grandfathered” Health Plans*, HEALTHCARE.GOV (describing the projected impact of the health care reform bill on consumers and health plans).

³⁰⁸ *See id.*

³⁰⁹ *Id.*

³¹⁰ *Id.*

³¹¹ *See* Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34559 (June 17, 2010) (adopting 26 C.F.R. § 54.9815-1251T(c)(1)); *id.* at 34563 (adopting 29 C.F.R. § 2590.715-1251(c)(1)); *id.* at 34567–68 (adopting 45 C.F.R. § 147.140(c)(1)).

³¹² *Id.* at 34562.

³¹³ *Id.* at 34559 (adopting 26 C.F.R. § 54.9815-1251T(c)(1)); *id.* at 34563 (adopting 29 C.F.R. § 2590.715-1251(c)(1)); *id.* at 34567–68 (adopting 45 C.F.R. § 147.140(c)(1)).

³¹⁴ *See* ACA, Pub. L. No. 111-148, sec. 1201, § 2707(a), 124 Stat. 119 (2010), *as amended* by Pub. L. No. 111-152, 124 Stat. 1029 (2010) (“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 . . .”).

Large group health plans also are exempt from the essential health benefits requirement.³¹⁵ Therefore, Congress should amend section 2707 of the Public Health Service Act to include the phrase “or large group” and to make conforming grammatical changes in order to require large group health plans to include the essential health benefits, as follows: “A health insurance issuer that offers health insurance coverage in the individual, small group, or large group market shall ensure that such coverage includes the essential health benefits package.”

F. Maintenance of Cost Exemption

Finally, federal mental health parity law contains a cost exemption that allows group health plans as well as health insurance issuers offering group or individual health insurance coverage to exempt themselves from compliance with federal mental health parity law if the application of such law results in an increase in the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan of two percent in the first plan year that mental health parity law is applied and one percent in each subsequent plan year.³¹⁶ The cost exemption is not mandatory; that is, a plan may elect to comply with federal mental health parity law regardless of any increase in total costs.³¹⁷ Because it is not anticipated that mental health parity will result in long-term cost increases,³¹⁸ Congress could maintain the cost exemption in federal mental health parity law. Should the dynamics of mental health economics change in a way that would cause mental health parity implementation to be associated with prohibitive health plan cost increases, health plans may opt out of mental health parity or Congress can revisit the cost exemptions at a later date.

VI. CONCLUSION

Public health care programs and private health insurers have long provided less comprehensive insurance benefits to individuals with mental illness. Although early mental health benefit disparities may have been justified by the belief that mental health care causes total health care costs to rise and that courts could easily distinguish physical and mental illness, these reasons are not supported in the current clinical, health care cost, and

³¹⁵ See *id.* (requiring health insurance issuers that offer health insurance in the individual and small group markets (but not the large group markets) to include the essential health benefits).

³¹⁶ See, e.g., 29 U.S.C. § 1185a(c)(2)(A), (B) (2006); 42 U.S.C. § 300gg-26(c)(2)(A), (B) (2006 & Supp. IV 2010).

³¹⁷ See, e.g., 29 U.S.C. § 1185a(c)(2)(A) (2006); 42 U.S.C. § 300gg-26(c)(2)(A) (2006 & Supp. IV 2010).

³¹⁸ See *supra* Part II.

legal literatures. This Article has proposed to reform federal mental health insurance law by removing remaining Medicare and Medicaid mental health benefit disparities and by extending the application of federal mental health parity law and mandatory mental health and substance use disorder benefit provisions to all individuals who have public and private health insurance. In so doing, this Article would effectively eliminate distinctions between physical and mental illness in the context of health insurance.

