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Bioethics, Parity, and the ACA: Why the ACA Does Not Go Far Enough

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I. AN INTRODUCTION: AN OVERVIEW

This article aims to analyze and critique the Affordable Care Act's (ACA) extension of mental health parity, and argues that the ACA falls short of the bioethical standards we require from our healthcare system. It also fails to properly provide healthcare to a sect of our population that is too often stigmatized, underserved, and desperately in need of comprehensive, non-traditional medical treatment.

I will address these issues in four parts. First, I will give a brief overview of mental illness and its treatment in the United States. At the heart of the issue of coverage for treatment of mental illness are the issues of moral hazard, adverse selection, and increased cost to insurers.¹ To understand why some insurance companies base their hesitation on these topics, it is best to understand the complexity that is the legal environment of mental health parity leading up to the Affordable Care Act.

Next, I will look at the ACA's goal of expanding mental health parity law and mandatory mental health and substance use benefits to most, but not all, individuals with both private and public health insurance.² In part III, I will look at the fundamental bioethics tenants that should be guiding the healthcare system, both for mental and physical health, in America. I will focus my discussion on how the ACA falls short of fully satisfying these tenants and how, if our Legislature used the bioethical tenants as more of a guide in structuring the ACA, it may be closer to achieving the goal of providing ample and quality care to mentally ill patients. In part

¹ Stacey Torino, All Illnesses are not created equal: Reforming Federal Mental Health Insurance Law, 49 Harv. J. on Legis. I (2012) UNLV William S. Boyd School of Law Legal Studies Research Paper Series. Available at SSRN: <http://ssrn.com/abstract=2031214>

² Id.

four, I will address concerns with the way some scholars – and courts – are seeking to remedy this situation, and offer my own introduction to a possible solution.³

The Affordable Care Act may open doors for mentally ill patients, but its failure to fully understand the complex bioethical tenants as they apply to mental illness and its failure to see that the stigma attached to mental illness extends not just from society but to insurance companies' policies leaves much to be desired.

2. A BRIEF HISTORY OF MENTAL HEALTH CARE IN THE UNITED STATES

In order to best understand the issues with the ACA, it is important to survey the various views on mental disorder and how our legal system has evolved in its understanding of mental health in the United States. This includes surveying the various theories of mental disorders, treatments, and access to care.

A. Theories of Mental Disorders

The treatment for mental health has evolved with our understanding of the cause of mental illness.⁴ There are conflicting views on the extent to which mental illness is a result of genetics, brain function, environmental factors, or learned behaviors.⁵ As a result, there are varying philosophies on the origin of mental illness, with the most prominent being biological, subconscious, and behaviorism.

The medical model, purported by Eric Kandel, puts forth five distinguishable guidelines for biologists' understanding of the cause of mental illness: disturbances of brain function; genetic; genetic and developmental factors working together; genetic alternations induced by

³ *Id.* Many courts are attempting to translate mental illness into physical illness, following the school of thought that mental illness is biological in causation and needs to be treated from a biological standpoint. *Id.*

⁴ Christopher Slobogin, Arti Rai & Ralph Reisner, *Law and the Mental Health System: Civil and Criminal Aspects* 3-4 (Thompson West, 5th ed. 2009).

⁵ *Id.*

learning causing changes to neurological connections; and changes to genetic expression resulting in structural and synaptic changes between nerve cells within the brain.⁶

Second, there are those who believe the biological effects on the psyche stem from the less obvious, specifically the unconscious. Sigmund Freud was a predominant scholar on this approach, which acts on the assumption that much of our mental life is unconscious and that past experiences shape how a person feels and behaves throughout life.⁷ The third and final major understanding for mental illness is known as behaviorism or the Social Learning Theory.⁸ Behaviorists, which includes such names as Pavlov and B.F. Skinner, believe that all behavior is learned from our observable environment, even our non-observable actions. Essentially, we are not born with any predispositions but rather learn them from our interactions with the observable world.⁹ Which theory one subscribes to impacts how one chooses to treat the mental disorder.

B. Treatments

While the treatment may be influenced by the theory of origin one subscribes to, the treatment options can essentially be boiled down to biological and non-biological.¹⁰ Biological treatments have resulted in a staggering increase in the use of psychopharmacologics.¹¹ Psychotherapy, while still a viable treatment option, is less prevalent

⁶ Eric R. Kandel *A New Intellectual Framework for Psychiatry in Law and the Mental Health System: Civil and Criminal Aspects* 8 – 11 (Thompson West, 5th Ed. 2009).

⁷ See: *Id.*; Saul McLeod, *Behaviorism*, Simple Psychology (published 2007), <http://www.simplypsychology.org/behaviorism.html>.

⁸ Kandel, *supra.*; McLeod, *supra.*

⁹ Kandel, *supra.*; McLeod, *supra.*

¹⁰ Slobogin, et al. *supra.*

¹¹ See Richard A. Friedman, *A Call for Caution on Antipsychotic Drugs*, New York Times, Sept. 24, 2012 available at http://www.nytimes.com/2012/09/25/health/a-call-for-caution-in-the-use-of-antipsychotic-drugs.html?_r=0; According to the New York Times, citing research from IMS Health, reports anti-psychotic drugs, used to treat major depressive episodes, schizophrenia, and bi-polar disorder, amounted to \$18.2 billion, being prescribed to 3.1 million Americans in 2011. *Id.* See also: Use of Mental Health Services and Treatment Among Adults, National Institute of

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with about 3.2 percent of the nation's population utilizing therapy as of 1997.¹² According to Dr. Mark Olfson, an associate professor of psychology at Columbia University and the lead author of a study on the use of psychotherapy from 1987 through 1997, "with all the attention given to antidepressants and other medications, the role of psychotherapy can be easily overshadowed."¹³ While it may be overshadowed, given that 9.69 million people still choose psychotherapy as a treatment option, it remains a viable treatment in mental health.¹⁴ The most popular means of treatment seems to be a combination of psychopharmacology and psychotherapy; In 1997, 61.5% of patients receiving psychotherapy also took psychotropic medication.¹⁵

The conjunction of both pharmaceuticals and therapy highlights the complex treatments available and often used to treat mental illness that go beyond traditional medication. Despite these unique characteristics, healthcare policy has attempted to reconcile mental healthcare with physical healthcare for years, despite their innate differences and intricacies.¹⁶

Mental Health (last visited December 10, 2012) *available at* http://www.nimh.nih.gov/statistics/3USE_MT_ADULT.shtml; SAMHSA's National Survey on Drug Use and Health (NSDUH) also found in 2008 that just over half (58.7 percent) of adults in the United States with a serious mental illness (SMI) received treatment for a mental health problem. Treatment rates for SMI differed across age groups, and the most common types of treatment were outpatient services and prescription medication. *Id.*

¹² Erica Goode, *Psychotherapy Shows a Rise Over Decades, But Time Falls*, *New York Times*, Nov. 20, 2002 *available at* <http://www.nytimes.com/2002/11/20/us/psychotherapy-shows-a-rise-over-decade-but-time-falls.html>.

¹³ *Id.*

¹⁴ *Id.*; *See also* Mark Olfson, M.D., M.P.H.; Steven C. Marcus, Ph.D.; Benjamin Druss, M.D.; Harold Alan Pincus, M.D. *National Trends in the Use of Outpatient Psychotherapy*, *National Institute of Mental Health The American Journal of Psychiatry*, VOL. 159, No. 1 (Nov. 2, 2002) *available at* <http://ajp.psychiatryonline.org/article.aspx?articleID=175859>.

¹⁵ Erica Goode, *supra.*; *See also* Slobogin, et al. *supra.*

¹⁶ Peter Domenici & Gordon H. Smith, *Americans are Waiting for Mental Health Parity*, *Washington Post*, April 12, 2012, *available at* http://www.washingtonpost.com/opinions/americans-are-waiting-for-mental-health-parity/2012/04/12/gIQANhrnDT_story.html.

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B. Access to Care in the United States

Legislation has attempted to address the problem of affordable access to mental health care for decades.¹⁷ Historically, there has either been a complete lack of coverage for treatment of mental health conditions or the coverage has been so minuscule it is practically non-existent.¹⁸ Previous laws never required coverage of mental health law or substance use but parity laws attempted to address the lack of mental health care.¹⁹ These laws required that when the insurer chose to cover mental health services, that coverage was required to be in compliance with federal mental health parity requirements.²⁰

The ACA relates to past parity laws in that it attempts to expand mental health coverage and treatment within the United States. Specifically, there have been the Mental Health Parity Act (“MHPA”) of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”).²¹ Each of these acts focused on parity, or equal coverage of mental health care when compared to medical and surgical care.²² The MHPA was the first parity law affecting the entire country.²³ By 2008, it became apparent that the intended

¹⁷ See Paul Wellstone Mental Health and Addiction Equity Act of 2007, Pub. L. 110-343 available at <http://www.gpo.gov/fdsys/pkg/PLAW-110publ343/html/PLAW-110publ343.htm>.

¹⁸ Amanda K. Sarata, Mental Health Parity and the Patient Protection and Affordable Care Act of 2010, Congressional Research Service, Dec. 28, 2011 available at <http://www.ncsl.org/documents/health/MHparity&mandates.pdf> at 1; See also <http://www.time.com/time/health/article/0,8599,1738804,00.html>: A 2008 article in Time Magazine reports that those suffering from serious mental illness (defined as a range of mood and anxiety disorders) cost our society \$193.2 billion in lost earnings per year, citing to a study from the American Journal of Psychiatry. *Id.*

¹⁹ Pub. L. 110-343, *supra*.

²⁰ Amanda K. Sarata, *supra*. at 2.

²¹ *Id.* at 3.

²² Mental Health Parity and Addiction Equity Act, American Psychological Association, available at <http://www.apa.org/helpcenter/parity-law.aspx>.

²³ Amanda K. Sarata, *supra*. at 3.

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effects of the MHPA were limited and so the MHPAEA was enacted, expanding the scope of federal parity requirements.²⁴ At its core, the MHPAEA sought to encourage employers to provide benefits for various medical treatments for their employees, such as inpatient mental health services.²⁵ In its details, the MHPAEA applied to all group health plans with more than 50 employees.²⁶ The legislation identified six categories where it required parity: inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency room services, and prescription drugs.²⁷ Within those areas, parity specifically affects financial requirements, treatment limitations, and annual and lifetime limits.²⁸ Furthermore, it did require annual and aggregate lifetime limits on “coverage for mental health services under group health plans and health insurance issuers offering group health coverage be no less than those for medical and surgical services.”²⁹

Despite these strides, the MHPAEA never mandated coverage of mental health services.³⁰ It also did not apply to Medicare patients.³¹ Additionally, there existed a lack of

²⁴ The MHPAEA also included substance abuse issues as those requiring parity under the MHPAEA. *See Id.*

²⁵ John T. Seybert, Esq. and Edward Stumpp, Esq., Will the Mental Health Parity and Addiction Equity Act of 2008 Successfully Encourage Employers to Provide Benefits for Inpatient Mental Health Treatment?, Sedgwick, Detert, Moran & Arnold, LLP & ABA Health eSource (March 2010) *available at* https://www.americanbar.org/newsletter/publications/aba_health_esource_home/Seybert.html.

²⁶ Mental Health Parity and Addiction Equity Act, American Psychological Association, *supra*.

²⁷ Mental Health Parity And Addiction Equity Act (MHPAEA), The KNW Group, *available at* http://www.nfpbenefitpartners.com/the_knw_group_llc/hr/Other_Federal_Mandates/MHPAEA.aspx.

²⁸ Amanda K. Sarata, *supra*. at FN1.

²⁹ *Id.* at 3.

³⁰ *See Id.* The document suggests that dropping coverage all together would be a rarity because of the expense of the services and citing a Kaiser Family study quoting 97% of all plans offering mental health services. The APA also notes the importance of treatment for mental health in achieving a full recovery from various physical illnesses, such as heart conditions. While I would agree with this, it seems the APA is not looking at the other side of the argument in relying on such assumptions and is doing a disservice to the public by not considering that there

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inclusion for alternative treatments and behavioral therapy – key components of mental health care. The MHPAEA’s failure to bring mental health coverage up to par with other medical services can be attributed to two major reasons. To begin with, the MHPAEA did not preclude employers from dropping coverage for a particular diagnosis.³² Additionally, it lacked a compulsion element – employers could simply choose not to cover mental health and substance abuse services all together.³³

The major issues with the MHPAEA were the lack of coverage for key insurance plans, including federally funded plans such as Medicare and Medicaid, as well as small group employers.³⁴ MHPAEA also included a notable cost exemption, where plans experiencing a cost increase of 1% as a result of complying with the parity requirements could be exempt from complying.³⁵

3. THE AFFORDABLE CARE ACT

A. The basics of the Affordable Care Act

are many other there who do not see mental health services as deserving equality with medical and surgical services because of there expense. *Id.*

³¹ MHPAEA protection was extended to Medicaid patients. *See* Mental Health Parity and Addiction Equity Act, American Psychological Association, *supra*.

³² American Psychological Association: Mental Health Insurance under Federal Parity Law (Oct. 2010) *available at* <http://www.apa.org/helpcenter/federal-parity-law.aspx>.

³³ 2012 Report to Congress: Compliance with the Mental Health Parity and Addiction Equity Act of 2008, United States Dept. of Labor, (Jan. 1 2012) *available at* <http://www.dol.gov/ebsa/publications/mhpaeareporttocongress2012.html#.UMdltrT3D-Y>.

³⁴ *See* Amanda K. Sarata, *supra*.

³⁵ The Mental Health Parity and Addiction Equity Act, The Center for Consumer Information & Insurance Oversight, *available at* http://cciio.cms.gov/programs/protections/mhpaea/mhpaea_factsheet.html.

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The ACA endeavors to provide more people with more extensive health care.³⁶ But for those individuals suffering from mental health disorders, the ACA presents a complicated reality. Nevertheless, the ACA should prove beneficial in assisting those with serious mental illness.³⁷ The ACA does expand access to insurance coverage and, because mental health services are listed as an Essential Health Benefit (EHB), consumers must receive at least some benefits related to mental health services.³⁸ However, the extent to which mental health services are covered are subject to significant loopholes, including medical necessity, exemptions for certain employers, and exemptions for plans which incur a certain amount of expense.³⁹ Additionally, there is confusion over the ACA's extension of the MHPAEA to Medicare and Medicaid.⁴⁰

Arguably, the ACA's strongest assets are the EHB, a list of ten categories which must be included in any comprehensive health insurance offering under the ACA.⁴¹ The EHB are purportedly defined through a state-by-state benchmark approach, where each state selects a plan that meets the need of its citizens.⁴² According to the regulations, states choose from the three largest small group plans, the three largest state employee health plans according to employment, the three largest federal employee health plan options by enrollment, or the largest HMO offered

³⁶ Susan Dentzer, Moving toward the "Triple Aim": The Affordable Care Act and the Implications for Payment and Quality Reform, (March 23, 2011) *available at* http://www.ehcca.com/presentations/pfpsummit6/dentzer_1.pdf.

³⁷ Insurance Market Reforms in the Patient Protection & Affordable Care Act and the Health Care Education Reconciliation Act, Bazelon Center, (Last accessed December 10, 2012) *available at* http://www.bazelon.org/LinkClick.aspx?fileticket=rLF-G4_8dbw%3D&tabid=137.

³⁸ What it means to have access to these services is not further defined. *Id.*

³⁹ Stacey Tovino, All Illnesses are (Not) Created Equal: Reforming Federal Mental Health Insurance Law. *supra*.

⁴⁰ *Id.*

⁴¹ Essential Health Benefits: HHS Information Bulletin, Healthcare.gov (February 24, 2012) *available at* <http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html>.

⁴² *Id.*

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in the state's commercial market according to enrollment numbers.⁴³ The default benchmark, should a state fail to choose one, is "the small group plan with the largest enrollment in the state."⁴⁴

EHB are critical to the health care reform because they guarantee some level of coverage for what are arguably the most important and most used health services. In reference to mental health services, currently 34 percent of those with health insurance do not have coverage for substance abuse problems and 18 percent have absolutely no coverage for any mental health services.⁴⁵

Notably, however, the federal government specifically chose not to define the Essential Health Benefits, instead leaving it to the states,

The (Institute of Medicine) recommended flexibility across States and suggested that States operating their own Exchanges be allowed to substitute a plan that is actuarially equivalent to the national (Essential Health Benefits) package.⁴⁶

This will inevitably lead to a lack of consistency between states on what mental health services are essential.⁴⁷ Furthermore, a lack of federal guidance allows for a huge variation amongst plans on what is and is not covered.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ See Essential Health Benefits: Individual Market Coverage: ASPE Issue Brief (Dec. 16, 2011), available at <http://aspe.hhs.gov/health/reports/2011/individualmarket/ib.shtml>; See also Rick Weiss, *U.S. Leads in Mental Illness, Lags in Treatment*, Washington Post (June 7, 2005) available at <http://www.washingtonpost.com/wp-dyn/content/article/2005/06/06/AR2005060601651.html>: Citing the National Comorbidity Survey Replication for support in finding One-quarter of all Americans fit the criteria for suffering from mental illness, with less than half of those getting treatment. *Id.*

⁴⁶ See Frequently Asked Questions on Essential Health Benefits Bulletin, Centers for Medicare & Medicaid Services, available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

⁴⁷ See Sarah Kliff, *In acupuncture essential health care? Weight-loss surgery? Under Obamacare, states choose*, Washington Post, (Sept. 22, 2012) available at <http://www.washingtonpost.com/blogs/wonkblog/wp/2012/09/22/is-acupuncture-essential->

B. The Shortcomings of the Affordable Care Act

The ACA falls short of extending mental health parity to the extent it needs to.⁴⁸ The ACA attempts to strengthen the failings of previous parity laws by requiring any and all plans originally covered under the MPA and MHPAEA to still remain consistent and in line with the MHPAEA.⁴⁹ In its most recent guidance issued on the matter, the Department of Labor clarified that the MHPAEA prohibits plans from imposing greater financial requirements or limitations on treatment on mental health and substance abuse care than those financial requirements and limitations on treatments to medical and surgical benefits.⁵⁰ Recognizing that there is more to healthcare than money and treatment limitations, the Department of Labor specified six “nonquantitative treatment limitations”:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods used to determine usual, customary, and reasonable fee charges;

health-care-weight-loss-surgery-under-obamacare-states-must-choose/. That states are allowed to choose what medical procedures are within the broad guidelines of the ten essential health benefits has already led to an array of variation for coverage of fertility treatments, acupuncture, chiropractic care, and ages at which dental coverage can be. It is likely that such deviation amongst states will continue, if not be exacerbated, when deciding mental health and substance abuse coverage. The article supports this at the very end, when the author points to Utah, whose plan lacks any substantial substance abuse benefits. *Id.*

⁴⁸ Amanda K. Sarata, *supra*.

⁴⁹ *Id.*

⁵⁰ It is further specified that requiring the benefits and financial responsibilities for mental health and substance abuse services to be on par with medical and surgical benefits includes not imposing separate financial requirements or treatment limitations on mental health and substance abuse services. United States Dept. of Labor, FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation *available at* <http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UI5Evjn3DR0>.

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- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
- Exclusions based on failure to complete a course of treatment.⁵¹

On all levels – both quantitative and nonquantitative – the Department of Labor merely requires that access to mental health services be no less restricted or burdened than access to medical or surgical services. The problems from the MHPAEA still remain. Specifically, coverage does not appear to extend to behavioral treatment, a key treatment option for those suffering from mental health conditions.⁵² For example, eating disorders are a recognized mental health disorder and often require extensive and complicated treatment, involving “medical care, mental health services, and nutritional therapy, requiring a team of specialists – often a primary care doctor, a therapist, a psychiatrist, and a dietician.”⁵³ Notably, eating disorders were not listed as covered under the EHB standards, despite efforts to the contrary.⁵⁴

By naming mental health care and substance abuse services as an EHB, the government is essentially forcing insurance plans to cover these services. In theory, then, the MHPAEA would require parity between the two and any physical coverage.⁵⁵ The close ties between the

⁵¹ *Id.*

⁵² See Shefall S. Kulkarni, Patients often find getting coverage for eating disorders is tough, *Kaiser Health News* (Oct. 19, 2012) *available at* <http://www.kaiserhealthnews.org/Stories/2012/October/19/binge-eating-disorder-insurance-coverage.aspx>.

⁵³ *Id.*

⁵⁴ *Id.*; See also Essential Health Benefits, Actuarial Value, and Accreditation Standards: Ensuring Meaningful, Affordable Coverage, *Healthcare.gov* *available at* <http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html>.

⁵⁵ See Parker, Smith & Feek, HHS Issues Bulletin on Definition of Essential Health Benefits, *available at* <http://www.psfinc.com/press/hhs-issues-bulletin-on-definition-of-essential-health-benefits>.

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ACA and the MHPAEA suggest that the success of the ACA hinges on the MHPAEA's failure being directly related to its lack of compulsion to cover any mental health care.⁵⁶

Such an understanding ignores the other failing of the MHPAEA – the extension of mental health coverage to all insurance plans, including publically funded ones such as Medicaid and Medicare. The most recent interim rule released by Health and Human Services addresses EHB, and the benchmark plan that states must choose, saying it will apply to non-grandfathered health care plans in the individual or small group market. According to Stacey Tovino, the ACA does not extend the parity laws to the federal healthcare programs.⁵⁷ The Congressional Research Services' analysis of the ACA and parity also confirms this.⁵⁸ The ACA expands previous parity laws to include qualified health plans, which are those plans defined in §130 - plans allowed to be offered in exchanges.⁵⁹ It also expands parity to benchmark and benchmark-equivalent Medicaid plans.⁶⁰ This still leaves a good portion of insurance plans with no mandate for parity. Further, the ACA fails to define what mental health services and substance abuse

⁵⁶ See generally Update Health Plans for Expanded MHPAEA & Health Care Reform Mental Health Mandates, Solution Law Press available at <http://slphrbenefitsupdate.com/2012/07/15/update-health-plans-for-expanded-mhpaea-health-care-reform-mental-health-mandates/>.

⁵⁷ Stacey Tovino, All Illnesses are (Not) Created Equal: Reforming Federal Mental Health Insurance Law. *supra*.

⁵⁸ Bernadette Fernandez & Annie L. Mach, Health Insurance Exchange Under the Patient Protection and Affordable Care Act (ACA), Congressional Research Service (Oct. 10, 2012) available at <http://www.fas.org/sgp/crs/misc/R42663.pdf>

⁵⁹ Amanda K. Sarata, *supra*.

⁶⁰ A benchmark or benchmark equivalent program is an optional program where a state can choose to “meet the needs of certain Medicaid population groups, target residents in certain areas of the state, or provide services through specific delivery systems.” See Benchmark Benefits, Medicaid.gov: Keeping America Healthy available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Benchmark-Benefits.html>. If a state does not provide the benchmark program, the Medicaid program is required to provide some sort of mental health care to its enrollees, though the type and extent of that care is not defined by the federal program. See <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Mental-Health-Services-.html>. *Id.*

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services are.⁶¹ So while the ACA requires parity for some health insurance plans, it has yet to be seen what each state will define as EHB. The federal government has regulated the States with defining the details of the EHB.⁶²

Regardless of whether the ACA covers mental health care for more people, it does nothing to incentivize better or more comprehensive care. Those suffering from serious mental illness experience a 78 percent unemployment rate and have a life expectancy 25 years shorter than others because they receive little or substandard care.⁶³ There appears to be a lack of quality assurances in the ACA, something that mirrors one of the reasons the MHPAEA may have failed to achieve its ultimate goal of parity. The majority of the ACA focuses on getting care to more people. There are parts of the ACA that are aimed to address the quality of care, but those may not be enough in the field of mental health care, which has been neglected for so long.⁶⁴

Looking at the ACA's quality assurances, it links payment to quality outcomes in Medicare.⁶⁵ This could prove beneficial. In addition to tying payments to quality assurances, the ACA also seeks to look into the quality infrastructure within the medical community to

⁶¹ Essential Health Benefits, Actuarial Value, and Accreditation Standards: Ensuring Meaningful, Affordable Coverage, Healthcare.gov *available at* <http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html>.

⁶² *See* The Federal Government releases long-awaited health reform rules, NBC News, November 20, 2012 *available at* http://vitals.nbcnews.com/_news/2012/11/20/15309331-federal-government-releases-long-awaited-health-reform-rules. "They also say when states outline so-called essential health benefits – the minimums of what health insurers should cover – they should use the best existing plans as a guideline." *Id.*

⁶³ Judge David L. Blazelon Center for Mental Heal Law, Integration of Mental Health in Quality Assurance Programs, *available at* <http://nacbhdd.org/content/Quality.pdf>

⁶⁴ *See generally:* The Patient Protection and Affordable Care Act: Detailed Summary: *available at* <http://dpc.senate.gov/healthreformbill/healthbill52.pdf>.

⁶⁵ *Id.*

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strengthen the delivery system.⁶⁶ Arguably, the strongest quality assurance within the ACA is its dedication to integrated healthcare delivery systems.⁶⁷ Pamela Hyde, an influential member of the Substance Abuse and Mental Health Services Administration, was a member of a panel discussion on the Diane Rehm Show, discussing mental health care under the ACA. When the issue of paying per procedure was brought up, Hyde pointed to the ACA's focus on Integrated Healthcare Delivery Systems. These require multidisciplinary teams to work together to provide care to the patient – allowing better communication between various medical professionals and better communication about the patient's treatment going forward and his quality of care in general.⁶⁸ Dr. Steven Davis, another panel member and member of the University of Maryland staff, elaborated on Hyde's point, that this will ensure providers are paid with "how well they keep someone on their outcomes and not on how many times they see him, how many visits they have, how many times they cut a mole off."⁶⁹

However, it has the potential to hinder mental health care services.⁷⁰ Specifically, with mental illness, the complexity of those disorders complicate holding providers accountable for outcomes.⁷¹ The Blazelon Center voices the concern that such a payment method may encourage providers to avoid consumers with the most serious disorders because of the expense and difficulty in treating, a practice known as creaming.⁷²

⁶⁶ *Id.*

⁶⁷ *See: Id.; See also* Radio interview from the Diane Rehm Show: *Mental Health Services under the Affordable Care Act* (July 31, 2012) available at <http://thedianerehmshow.org/shows/2012-07-31/mental-health-services-under-affordable-care-act/transcript>.

⁶⁸ The Diane Rhem Show, *supra*.

⁶⁹ *Id.*

⁷⁰ <http://www.kaiserhealthnews.org/stories/2012/april/15/medicare-doctor-pay.aspx>

⁷¹ Bazelon Center for Mental Health Law: Integration of Mental Health in Quality Assurance programs, *supra*.

⁷² *Id.*

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The Bazelon Center for Mental Health has done extensive research on this area, and notes that the Institute on Medicine identified six areas that, if focused on, would improve the quality of mental healthcare: patient-centeredness, safety, effectiveness, timeliness, efficiency, and equity.⁷³ The use of integrated methods of delivery of medical care, or Accountable Care Organizations, is incredibly promising to treat mental illness.⁷⁴ However, it remains to be seen if the coverage will be carried through. The ACA does not change the pay per procedure system – rather, it encourages research and the use of ACOs.⁷⁵

4. BIOETHICAL TENANTS

Biomedical ethics are of specific interest to those attempting to understand the best ways to address mental illness in the United States, having influenced past legal trends in mental healthcare.⁷⁶ Biomedical ethics have “assumed a kind of principlist orientation over the past 30 years, in which ethical principles at best operate primarily as checklists naming issues worth remembering when considering a biomedical moral issue”⁷⁷. These principles, which can be considered the fundamental principles of Bioethics,⁷⁸ are autonomy; non-maleficence; beneficence; confidentiality; distributive justice; and truth telling.⁷⁹

⁷³ *Id.*

⁷⁴ How Health Care Reform Can Improve Care for People with Chronic Health Conditions (including individuals with serious mental illnesses), Judge David L. Bazelon Center for Mental Health, *available at*

<http://www.bazelon.org/LinkClick.aspx?fileticket=Tf8iX-DlvaQ%3D&tabid=218>

⁷⁵ The Patient Protection and Affordable Care Act: A Detailed Summary, Democratic Policy & Communications Center, *available at* <http://dpc.senate.gov/healthreformbill/healthbill52.pdf>

⁷⁶ Slobogin, et al. *supra*.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

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Bioethics began to focus on mental illness in the late 1960s and early 1970s, primarily focusing on involuntary hospitalization and psychosurgery.⁸⁰ During this time, physicians enjoyed essentially unlimited control over their mentally ill patients, with little to no legal oversight.⁸¹ By the 1970s and 1980s, the courts interceded, curbing the physicians' ability to civilly commit patients against their will, with state statutes and regulations following thereafter, and there was a move towards decentralization.⁸² Community health services were on the rise, as was pharmaceutical remedies for mental illness.⁸³ The decentralized delivery system is the system we are familiar with today, where a collaborative and community orientated treatment system is often employed, using social workers, psychiatrists, and psychologists.

There were two countering philosophies guiding the treatment of mental health until the decentralization of the mental health delivery system: paternalism⁸⁴ and autonomy.⁸⁵ Paternalism refers to either physician paternalism and *parens patriae*.⁸⁶ Physician paternalism, popular until the late 1960s, involved physicians wielding broad authority over psychiatric patients, almost to the extent of state authority.⁸⁷ The uninhibited nature of the 1960s was eventually curbed, and courts have used state statutes and regulations, furthered by scandals with institutionalization of psychiatric patients, the civil rights movement, and reform for state

⁸⁰ Janet Nelson, Bioethics and the Marginalization of Mental Illness, *Journal of the Society of Christian Ethics*, 23,2 (2003).

⁸¹ *Id.* at 184.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ Leonard Rubenstein, *Law and Priority Setting, What Price Mental Health? The Ethics and Politics of Setting Priorities*, (Philip J. Boyle & Daniel Callahan) 100 – 114

⁸⁵ Nelson, *supra*.

⁸⁶ *Id.*

⁸⁷ Rubenstein, *supra*.

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benefits for the poor, to limit the ability of professionals to civilly commit and intervene without the consent of the patient themselves.⁸⁸

Parens patriae involves the state's right to intervene on paternalistic grounds, or in the "interest of humanity."⁸⁹ Eventually, the courts brought these abuses under control by defining a clear legal standard that must be met prior to requiring civil commitment against the will of the patient.⁹⁰ The state's paternalistic interest was eventually viewed under the "constitutional principle that the exercise of state authority over individuals against their will be limited to those circumstances where the state has a compelling interest."⁹¹

Autonomy, the right to be self-determining, factors heavily into our understanding of treatment for mental illness today⁹², but was less of a presence in the mid part of the last century. It was severely limited by the paternalistic notions, and the "harm principle, the justification or right to intervene or to set restrictions to prevent harm to others."⁹³ Decentralization supported the move towards autonomy.⁹⁴ The more control the patient has in determining their care, the more autonomy they exercise. When dealing with patients battling mental illness, autonomy may not function in the same manner as other medical-decision making cases.⁹⁵ In Janet Nelson's article "Bioethics and the Marginalization of Mental Illness," Nelson suggests our society's "obsession" with autonomy has conflated the meaning of the word when it comes to the mentally ill. Nelson believes that our misconception of how it can be applied to the mentally ill

⁸⁸ *Id.* at 100 – 101.

⁸⁹ *Id.* at 100; Nelson, *supra.* at 181.

⁹⁰ Rubenstein, *supra.* at 103.

⁹¹ *Id.*

⁹² Nelson *supra.*

⁹³ Nelson, *supra.* at 181.

⁹⁴ *Id.*

⁹⁵ *Id.* at 186.

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may have contributed to the current political-socioeconomic issue with access to mental health care in the United States.⁹⁶

Regardless of the success of the ACOs, the six focus areas previously identified by the Bazelon Center for Mental Health as key to improving the quality of medical care are in-line with some of the bioethical principles. Specifically of interest is the patient-centered aspect of care and its relationship to paternalism and principlism.

Patient-centered care means putting the patient as the focal point of all decisions.⁹⁷ This may seem obvious, but more often, our current system focuses on the business aspect, with insurance being the driving force behind many decisions.⁹⁸ It may also seem obvious the means by which to make the patient the focal point of the care, but it may prove to be more difficult given the competing interests always at stake in making medical decisions. The Blazelon Center offers specific ways to accomplish this important goal, including changes to the service delivery system to make it more consumer friendly.⁹⁹ Additionally, the Blazelon Center cites shared decision-making, based on improved access to information and available treatments.¹⁰⁰

Principlism is the term employed to describe a framework based on the balancing of four ethical principles: nonmaleficence, beneficence, justice, and autonomy.”¹⁰¹ The bioethical framework of principlism may, if applied to the legal framework, properly balance an individual’s right to autonomy with the other bioethical tenants, leading to a fair and more ethical system of mental health care. The ACA, as well as previous mental parity laws, lack

⁹⁶ *Id.*

⁹⁷ Robert A Peraino, MD, FACP, Why Patient Centered Care?, Patient Centered Care, (Last accessed Dec. 10, 2012), *available at* <http://www.patientcenteredcare.net/>.

⁹⁸ *See Id.*

⁹⁹ Blazon Center for Mental Heal Law: Integration of Mental Health in Quality Assurance Policies, *supra*.

¹⁰⁰ *Id.*

¹⁰¹ *Id.* at 186

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principlism's influence, demonstrated by the limitations placed on access to care.¹⁰² Principlism's balance of bioethical principles, specifically justice, beneficence, and nonmaleficence, would provoke more access to comprehensive mental health care than has been previously protected by parity laws, and which appears to be missing from the ACA.¹⁰³ Many scholars cite stigma as a possible contributing factor to this disconnect,¹⁰⁴ as well as adverse selection and fraud.¹⁰⁵

The stigma results from a lack of understanding of mental illness, and insurance companies, society, the judiciary, and the government being more comfortable with the physical illness approach. There was a push in the 1980s to recognize mental illness as a type of physical illness because of the advances in understanding mental illness as stemming from biological origins.¹⁰⁶ While classifying mental illness as a physical illness might get coverage for certain people in certain situations, it falls short of achieving the parity that those suffering from mental illness so rightly deserve. Furthermore, it does not reflect a true understanding of what mental illness is. There are plenty of mental deficiencies we do not understand the basis of – and it would limit the coverage to the physical aspects of it, ignoring the often necessary treatment plans that are considered non-traditional, such as psychotherapy.

¹⁰² See generally Nelson *supra*.

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 193

¹⁰⁵ Stacey Tovino, Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits (February 1, 2012). *Annals of Health Law*, Vol. 21, p. 147, 2012; UNLV William S. Boyd School of Law Legal Studies Research Paper Series. Available at SSRN: <http://ssrn.com/abstract=2005950>. Tovino goes into great lengths over private insurance companies' hesitations in covering mental illness, including the market effects of their doing it and other companies not. This in-depth discussion is tangential to the issue in this paper, as stigma is the greater overarching component as connected to bioethics. *Id.*

¹⁰⁶ *Id.*

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Efficacy measurements are different in the mental health context from any other health related field. The ACA puts tremendous focus on efficacy and outcomes in determining access to healthcare.¹⁰⁷ Nelson critiques the focus on autonomy, finding it limits an analysis to the choices to an either/or practice, and does not focus on the larger issues at play in that decision.¹⁰⁸ That seems to be precisely the problem with today's health care delivery system, which does not recognize the limitations on a person's autonomy in decision making because of the insurance practices and pay per procedure model currently used. Mental health issues are so fundamentally different than health issues in general that the community health centers need to be geared towards supporting just mental health. In order to ensure that people's autonomy is not compromised, we must see mental health elevated not just to parity, but as a priority. Our society's neglect of mental health access, care, education, and acceptance has put it so far behind medical and surgical care in terms of access. If we were to make access to quality mental health care a priority, we would be well on the road to possibly reaching patient autonomy in mental health care.

Soaring health care costs have led many programs, including the States, to cut back on funding for mental health services.¹⁰⁹ This is despite our nation earning an overall grade of "D" for public mental health services as of 2009.¹¹⁰ In assessing this national grade, the National Alliance for Mental Illness assessed state efforts in health promotion and measurement;

¹⁰⁷ Administration Implements New Health Reform Provision to Improve Care Quality, Lower Costs, Healthcare.gov, available at <http://www.healthcare.gov/news/factsheets/2011/04/valuebasedpurchasing04292011a.html>

¹⁰⁸ *Id.*

¹⁰⁹ See generally Melissa Silverberg & Bob Kazel, Mental-Health Cuts by U.S. States Risk Boosting Health Costs, Bloomberg News (Feb. 26, 2012) available at

¹¹⁰ The State of Public Mental Health Services Across the Nation, National Alliance for Mental Illness, available at <http://www.nami.org/gtsTemplate09.cfm?Section=Findings&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75255>.

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financing and core treatment & recovery services; consumer and family empowerment; and community integration and social inclusion.¹¹¹ In their research, they found that many patients suffering from mental illness eventually succumbed to preventable complications, such as suicide and cardiovascular disease.¹¹² The report came out in 2009 – before the ACA was enacted – and found that more than 45 million Americans had no insurance for health care, and few states offered alternatives for these individuals to receive treatment.¹¹³ Private health insurance repeatedly fell short of parity, leading to an overburdened public system and overutilized emergency rooms.¹¹⁴ That the ACA fails to set some sort of floor for what states must cover in terms of minimum mental health and substance use disorder benefits suggests our country will continue to see this trend of millions of Americans seeking treatment through emergency rooms, since emergency services are listed as one of the EHB under the ACA.¹¹⁵

Principlism – with the four tenants of autonomy, justice, nonmaleficence, and beneficence- are not all met when there is a lack of access to care. Certainly the Affordable Care Act has brought us closer to achieving harmony with the bioethical tenants, but our society has not yet achieved conformation with the bioethical tenants. The success or lack thereof of the ACA will really determine how close we can get to fulfilling our bioethical responsibilities. And much of that success is tied to the Medicaid program, and if states will, indeed, expand it to include more uninsured persons.¹¹⁶

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *See generally* Edward I. Leeds and Jean C. Hemphill, HHS defines ‘essential health benefits’ under PPACA, *Employee Benefit News* (Dec. 7, 2012) *available at* <http://ebn.benefitnews.com/news/hhs-defines-essential-health-benefits-ppaca-2729494-1.html>

¹¹⁶ APA Response to Supreme Court Decision on Affordable Care Act, American Psychological Association, *available at* <http://www.apa.org/news/press/statements/affordable-care-act.aspx>

5. WHAT NOW?

Going forward with a better understanding of the complexities of mental healthcare treatment and the need for bioethical influence on our mental healthcare system, it becomes apparent that the law cannot address both mental and physical health in the same piece of legislation. To achieve true parity, we must not conflate mental health with physical health and appreciate them both for their unique and separate characteristics.

There has been much criticism over the ACA being too large and encompassing too much.¹¹⁷ This may or may not be true, but to lump mental health and substance use services into a list of ten essential health benefits minimizes the complexities within both of these unique and underserved health services. Given our country's history of minimizing and shunning mental health and substance use disorders,¹¹⁸ mental health and substance use disorders and their treatment should be dealt with in an entirely separate legislation, so as to pay close attention to the intricacies of the various diseases within those subsections. A separate legislation would also be able to take into account in a more manageable manner the measurement of efficacy challenges insurance companies face in evaluating various treatments, as well as the steps necessary to fight the stigma of mental and substance abuse disorders amongst insurance companies.

The current legislation addresses an outdated understanding of how mental disorders are treated, addressing mental disorder from a purely biological/physiological standpoint. This ignores that mental disease affect more than the physical person, and the other parts of the person

¹¹⁷ See Larry Lubell, Obama's Healthcare Bill before the Supreme Court, Urban Insurance Agency, *available at* <http://www.urbaninsuranceagency.com/obamas-healthcare-bill-supreme-court/>.

¹¹⁸ Stacey Tovino, Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits, *supra*.

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– their interactions with society, their ability to handle day-to-day tasks and be a productive member of society – also need treatment in order for a person to truly be healthy. The World Health Organization has, since 1948, defined health as “a state of complete physical, mental, and social well-being and not merely absence of disease or infirmity.”¹¹⁹ Going with this international standard, the United States should follow suit and bring our current health care system into alignment with the World Health Organization’s understanding, as well as the bioethical tenants.

In addition to concerns about the place of mental health services in healthcare legislation, the financial support- or lack there of – is also something that must be addressed and quickly. A February 2012 article in the Bloomberg news found that States looking to balance their budgets were cutting mental health facilities and Medicare payments.¹²⁰ These cuts amounted to more than \$1.6 billion in cuts between 2009 and 2012.¹²¹ Despite the Supreme Court’s upholding of the ACA, these cuts won’t be rectified, given the lack of definition of a minimum standard for mental health services will be.¹²²

Cutting mental health services in an attempt to balance a budget does not actually save taxpayers money in the long run. Those suffering from mental illness *need* care, and if they cannot afford it through insurance programs, either private or public, they will end up in the Emergency Room where treatment may be more expensive, less helpful, and therefore drains the

¹¹⁹ Stacey Tovino, Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits, *supra*.

¹²⁰ Melissa Silverberg & Bob Kazel, *supra*.

¹²¹ *Id.*

¹²² *See generally* Essential Health Benefits. States will determine the minimum set of benefits to be included in individual and small group insurance plans. What lies ahead?, Robert Wood Johnson Foundation, *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_68.pdf

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system.¹²³ “More use of ERs by people with mental illness...could mean additional overcrowding and making it harder for doctors to promptly see those who can pay, those with private insurance, and patients with nonpsychiatric illnesses and injuries. It also puts further strain on hospitals already struggling with balance-sheet pressure due to state reimbursement cuts to providers.”¹²⁴ In that same article, MaryLynn McGuire Clarke, senior director at the Illinois Hospital Association, points out that these mental illnesses don’t go away, and therefore present a long term strain on the system if there are not adequate resources provided to those suffering.¹²⁵

The financial burden goes beyond payment for the treatment, with untreated mental illness resulting in at minimum \$105 billion in lost productivity annually.¹²⁶ In both aspects – be it cost of care or cost of untreated mental illness on workplace productivity – the failure to properly fund and address mental illness drains our country’s finances.

The burden, then, will continually be passed onto hospitals, whose only means of collection is typically Medicaid.¹²⁷ Medicaid’s reimbursement rates are so low that many doctors refuse to take it, and many ERs cannot find permanent placements for its psychiatric patients.¹²⁸ With many states, including New Jersey, declining to participate in the Medicaid

¹²³ See generally *Id.*, Melissa Silverberg & Bob Kazel, *supra*.

¹²⁴ Melissa Silverberg & Bob Kazel, *supra*.

¹²⁵ *Id.*

¹²⁶ Vivien Giang, Untreated Mental Illnesses Are Costing American Companies Billions Every Year, *Business Insider* (Sept. 29, 2012), available at <http://www.businessinsider.com/you-dont-even-know-how-many-mentally-ill-people-youre-working-with-2012-9>.

¹²⁷ *Id.*

¹²⁸ *Id.*

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expansion under the ACA, the dichotomy between patients needing mental health care and the burden of providing such care will continue to grow.¹²⁹

What is essentially happening, in my opinion, is a perfect storm scenario – where legislators believe they are expanding mental healthcare to those who need it while failing to define minimum standards for said mental healthcare. With each state determining that floor independently and possibly choosing to opt-out of the Medicaid expansion, we will see an increased number of the mentally ill resorting to emergency care for treatment. This will further the burden placed on hospital – and in turn, on States and taxpayers, continuing the cycle of increased mental healthcare costs with subpar treatment.¹³⁰

Further complicating this scenario is the issue of medical necessity.¹³¹ Those suffering from mental illness often need treatments beyond what may be “medically necessary” in order to become a productive and self-sustaining member of society.¹³² The lack of a definition of medical necessity that understands the complexities of treatment for mental illness will only further aggravate the cyclical relationship of financial burdens attempting to be solved by cutting mental health services.¹³³

¹²⁹ *See generally* Where each state stands on ACA’s Medicaid Expansion, The Advisory Board Company, (Dec. 12, 2012) *available at* <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>.

¹³⁰ *See generally* U.D. Spending on Mental Health Care Soaring: rate of increase outstrips that for heart disease, cancer data shows, U.S. News HealthDay, (Aug. 5, 2009) *available at* <http://health.usnews.com/health-news/family-health/brain-and-behavior/articles/2009/08/05/us-spending-on-mental-health-care-soaring>. The cost of treatment for mental illness reached almost \$58 billion in 2009, according to information from the U.S. Department of Health and Human Services. *Id.*

¹³¹ Naomi Freundlich, Is Achieving Mental Health Parity a Pipe Dream?, Health Beat, (Jan. 31, 2011), *available at* <http://www.healthbeatblog.com/2011/01/is-achieving-mental-health-parity-a-pipe-dream/>.

¹³² Vivien Giang, *supra*.

¹³³ *See generally* Sara Rosenbaum, ‘Medical Necessity’ Definition Threatens Coverage for People with Disabilities, HealthAffairs Blog (Sept. 16, 2011) *available at*

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A solution is not easy to come by. However, the cost of not treating mental illness certainly appears to outweigh the cost of giving it the attention it deserves. In terms of the ACA, I believe the federal government needs to have more of a hand in defining standards for states to follow, specifically when it comes to historically underserved treatments, such as those for mental illness and substance use disorders. By starting broadly and using the ACA as a vehicle to highlight the struggles of the mentally ill in the United States, we can start the conversation about the need for reform in this area and the difficult. The details can come about as we go, but until we break down the stigma attached and get a better understanding of this epidemic in our workforce and our society, we cannot even begin to tackle the problem. Too often, the battles of the mentally ill are shrouded in secrecy and occur behind closed doors, with embarrassment and shame attached to the struggles.¹³⁴ If we force this discussion to the forefront, and force the treatments to be covered by all insurance programs in all states, we can slowly start to address this overwhelming epidemic.

<http://healthaffairs.org/blog/2011/09/16/medical-necessity-definition-threatens-coverage-for-people-with-disabilities/>

¹³⁴ *Id.*