

REVOLUTIONIZING THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

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I. INTRODUCTION

Timothy O'Clair was an ordinary boy who grew up with two brothers in upstate New York, in a spacious brick home near the city of Schenectady.¹ In March 2001, Timothy hanged himself in his closet using a sash from a bathrobe.² Two significant developments occurred between the time that Timothy was a typical second grade student, and when he took his own life several years later: the onset of numerous mental health conditions, and various discriminatory actions taken by his health insurance provider.³

Timothy initially exhibited signs of a mental health condition in the third grade, when he started experiencing flashes of severe anger.⁴ He subsequently assaulted his mother, tossed flammable materials into the furnace, and threatened to kill himself on a regular basis.⁵ After seeking professional psychiatric assistance, Timothy was eventually diagnosed with three separate conditions: attention deficit hyperactivity disorder, depression, and oppositional defiant disorder.⁶

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¹ Michael Hill, *Parents of Suicide Victim Urge Changes in Insurance*, L.A. TIMES (June 22, 2003), <http://articles.latimes.com/2003/jun/22/news/adna-tim22>.

² *Id.*

³ *See id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

Although he received quality psychiatric care, Timothy's health insurance provider limited his annual coverage for mental health conditions to twenty days of outpatient care and thirty days of inpatient care;⁷ notably, his medical and surgical coverage was not nearly as restrictive.⁸ Due to these discrepancies in coverage, Timothy's parents were forced to spread his treatments out over long periods of time, in an attempt to remain within the limitations of the coverage provided.⁹ Eventually, feeling that these limitations left them with no viable alternative, Timothy's parents painfully surrendered custody of Timothy and placed him in foster care where he would be eligible for Medicaid, which provided him with exponentially less restrictive coverage.¹⁰ Timothy's various mental health conditions improved dramatically before he was brought back home in January 2001.¹¹ He killed himself six weeks later.¹²

After this horrific incident, Timothy's parents lobbied the New York State Legislature demanding that health insurance providers be legally mandated to offer equal coverage for physical *and* mental health conditions.¹³ They implored the Legislature that mental health conditions be treated no differently than physical conditions, in regard to insurance coverage.¹⁴ They believed that such a law may have aided Timothy in his time of need, and would spare other parents from being compelled to make the inconceivable choices that they—Timothy's parents—were obliged to make.¹⁵ On December 26, 2006, New York Governor George Pataki signed such a bill into law;¹⁶ it is ubiquitously

⁷ Hill, *supra* note 1, at 1–2.

⁸ See *Timothy's Story*, TIMOTHY'S L., http://www.timothyslaw.org/timothys_story.htm (last visited Feb. 2, 2016) (explaining that although initially Timothy's physical and mental health insurance copayments were each ten dollars, the mental health visits increased to thirty-five dollars after just a few visits, and the family was soon thereafter forced to pay for the visits entirely out of pocket).

⁹ Hill, *supra* note 1, at 1–2.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ See *Timothy's Law Timeline*, TIMOTHY'S L., <http://www.timothyslaw.org/timeline.htm> (last visited Nov. 7, 2016) (“O’Clairs meet with Legislators in Albany to ask for passage of Timothy’s Law.”).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ See generally Richard Pérez-Peña, *Pataki Signs Bill on Parity in Healthcare*, N.Y. TIMES (Dec. 23, 2006), http://www.nytimes.com/2006/12/23/nyregion/23mental.html?_r=0 (“Ending months of uncertainty, Gov. George E. Pataki yesterday signed into law a bill requiring that commercial insurance policies pay for mental health care in much the same way they cover physical illness.”).

referred to as “Timothy’s Law.”¹⁷

In recent years, almost every state has recognized the importance of requiring parity in mental health coverage, and they have enacted laws designed to meet this imperative objective.¹⁸ The federal government has also made great strides in this regard, which include the enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008¹⁹ (MHPAEA), which will be discussed at length in this Comment, as well as the Patient Protection and Affordable Care Act²⁰ (ACA). Yet, despite the extraordinary measures recently taken, health insurance providers still discriminate against those with mental health conditions. This is evident in cases such as *New York State Psychiatric Association v. UnitedHealth Group*, in which one of the plaintiffs, an individual named Jonathon Denbo, sued his health insurance provider for violating the MHPAEA.²¹ In this case, Denbo suffered from dysthymic disorder and generalized anxiety disorder, and began seeing an out-of-network psychologist.²² Although Denbo’s insurance company initially processed and reimbursed the psychologist for his claims, after a few weeks they conducted a “medical necessity review,” determined that Denbo’s treatment was no longer “medically necessary,” and discontinued his coverage.²³ Would Denbo’s health insurance provider have discontinued his coverage had he suffered from a congenital heart defect or an endocrine disorder? Surely not.

The impetus for writing this Comment was the poignant narratives of individuals such as Timothy O’Clair and Jonathon Denbo, who were discriminated against by their health insurance providers

¹⁷ See 2006 N.Y. Laws 748.

¹⁸ See generally Richard Cauchi & Karmen Hanson, *Mental Health Benefits: State Laws Mandating or Regulating*, NAT’L CONF. OF ST. LEGISLATURES (Dec. 30, 2015), <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> (giving a general overview of the parity laws that exist in each state).

¹⁹ See generally Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 100-343, §§ 511–12, 122 Stat. 365 (codified as amended at 29 U.S.C. § 1185a (2012) & 42 U.S.C. § 300gg-26 (2012)).

²⁰ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified primarily in various sections of Titles 5, 18, 20, 21, 25, 26, 31, and 42 of the United States Code).

²¹ See *N.Y. State Psychiatric Ass’n v. UnitedHealth Grp.*, 798 F.3d 125, 130 (2d Cir. 2015), *cert. denied*, 136 S. Ct. 506 (2015).

²² *Id.* at 129.

²³ *Id.* (“Although United initially granted Denbo’s claims, it conducted a concurrent medical necessity review while Denbo was still undergoing treatment . . . [and] in May 2012 United told Denbo that his treatment plan was not medically necessary and that United would no longer provide benefits for his psychotherapy sessions.”).

despite the existence of federal laws that were intended to prevent exactly that. Mandating parity in healthcare coverage at the federal level was accomplished in large part by the MHPAEA, which mandates, *inter alia*, that the financial requirements and treatment limitations for mental health or substance abuse disorders are not more restrictive than the benefits for medical and surgical coverage.²⁴ The MHPAEA, however—which undoubtedly made exceptional strides towards achieving parity in healthcare coverage—still contains numerous loopholes that permit employers and insurance companies to continue discriminating against those seeking coverage for mental illnesses.²⁵ This Comment argues that several revolutionary measures need to be taken in order to bolster the MHPAEA and continue the trend towards complete parity in coverage by health insurance providers. This upwards trajectory towards parity is already underway; it was initiated by state parity laws, and was bolstered at the federal level by the MHPAEA. Recently, even greater strides towards parity in healthcare coverage were made at the federal level, with the passing of the ACA.

Part II of this Comment provides a background on the history of discrimination against the mentally ill and the lingering effects of that inequity in contemporary society. Part III discusses the reactions of various states, and the federal government, to this precarious issue. Part IV focuses on the MHPAEA, outlines the deficiencies in the legislation, and delineates several amendments and proposed statutory language that would bolster the MHPAEA considerably, if enacted. Part V concludes.

II. THE HISTORY OF DISCRIMINATION AGAINST THOSE WITH MENTAL HEALTH CONDITIONS AND THE PERVASIVENESS OF SIMILAR INEQUITIES IN CONTEMPORARY SOCIETY

Throughout much of history, individuals suffering from mental health conditions were discriminated against, and treated quite differently from those afflicted with physical ailments. Although the treatment of the mentally ill in today's contemporary society is not as blatantly opprobrious as it was in decades prior, it is critical to understand the history of this discrimination in order to fully comprehend the continued existence of this bigotry, albeit in a different form, by health insurance providers.

²⁴ 29 U.S.C. § 1185a (2012).

²⁵ *See, e.g.*, § 1185a(c)(2)(A) (outlining the cost exemption to the MHPAEA, which states that if implementation of the law will increase total costs to a health insurance provider by certain minimal percentages, then the “provisions of this section shall not apply to such plan”).

A. Historical Attitudes Towards Mental Illness

1. The Middle Ages

Historically, mentally ill individuals dealt with more pressing concerns than disparity in healthcare coverage; in fact, they were brutalized and oppressed for centuries. Throughout the Middle Ages, those afflicted by mental illnesses were oftentimes accused of witchcraft and were subsequently burnt at the stake.²⁶ Those not burnt publicly were commonly suspected of being possessed by demons and other ethereal forces, and were consequently shackled, thrashed, beaten, or subjected to exorcism ceremonies.²⁷ Often, mentally ill individuals additionally underwent medical “procedures,” which attempted to cure them of their maladies.²⁸ Such procedures included bloodletting the mentally ill individual, or, less violently, muttering incantations and utilizing “magical” herbs.²⁹ Traditionally, treatment of the mentally ill was also the responsibility of their family members.³⁰

2. Colonial Nineteenth & Twentieth Century America

In colonial America, the mentally ill were treated no better than they were in the Middle Ages.³¹ Oftentimes the mentally ill were imprisoned in workhouses, bound to the walls or floors, or institutionalized in exceedingly unsanitary structures.³² In some cases, the mentally ill were chained for extended periods of time, to the extent that they would often lose their limbs and die from the lack of proper food and nutrition.³³ There were some new promising approaches, however, that changed how mental health conditions were dealt with and perceived. Some individuals that were housed in asylums encountered these novel techniques, which attempted to increase the respect given to patients, avoided chaining them, and encouraged a healthy lifestyle and responsible living.³⁴ Despite these positive sentiments, mentally ill patients were still treated with bleeding procedures, laxative treatments, and “blistering,” in which a patient’s skin was charred with corrosive chemicals in an attempt to leach them

²⁶ IRMO MARINI & MARK A. STEBNICKI, *THE PSYCHOLOGICAL AND SOCIAL IMPACT OF ILLNESS AND DISABILITY* 27 (6th ed. 2012).

²⁷ *See id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 28.

³¹ *See id.* at 28–29.

³² MARINI & STEBNICKI, *supra* note 26, at 28.

³³ *Id.*

³⁴ *Id.* at 29.

of their “poisonous humors.”³⁵ Many mentally ill patients were also involuntarily sterilized, so as to prevent their theoretical descendants from genetically receiving their mental disability.³⁶ Some state laws even advocated such behavior, as evidenced by California’s Asexualization Act of 1909.³⁷

3. Twentieth Century Trends Towards Treating the Mentally Ill

During the early twentieth century, however, the public’s perception of the mentally ill and the manner in which they were treated began to change drastically,³⁸ leading to a myriad of new techniques that doctors would use in an attempt to “cure” their mentally ill patients. Such treatments included inducing fevers, and performing shock therapies and psychosurgeries, such as lobotomies.³⁹ Finally, in the 1920s, treatments for the mentally ill began to shift away from violent medical procedures, and physicians turned instead to psychoanalysis, also known at the time as the “talking cure,”⁴⁰ in which patients would communicate with their doctors in a wholesome environment. Sigmund Freud, the renowned Viennese psychiatrist, was one of the innovators of this method of psychoanalysis.⁴¹

B. *The Pervasiveness of Mental Illness in Contemporary Society*

1. Ubiquity of Mental Health Conditions in Modern America

During the course of any given year, nearly one in four American adults has some form of a diagnosable mental disorder.⁴² Suicide is the eleventh most frequent cause of death overall, and the third most

³⁵ *Id.*

³⁶ *Id.* at 30.

³⁷ MARINI & STEBNICKI, *supra* note 26, at 30; *see also* Janet Simmonds, *Coercion in California: Eugenics Reconstituted in Welfare Reform, the Contracting of Reproductive Capacity, and Terms of Probation*, 17 HASTINGS WOMEN’S L.J. 269, 273 (2006) (emphasis added) (internal citations omitted) (“In 1909, California became the second state to pass a sterilization law. The statute, called the Asexualization Act, provided for the involuntary sterilization of certain categories of people, including . . . certain institutionalized persons . . .”).

³⁸ *See* MARINI & STEBNICKI, *supra* note 26, at 32–33.

³⁹ *Id.* at 33–34.

⁴⁰ *Id.* at 34.

⁴¹ *Id.*

⁴² RACHEL VANSICKLE-WARD, *THE DEVIL IS IN THE DETAILS: UNDERSTANDING THE CAUSES OF POLICY SPECIFICITY AND AMBIGUITY* 81 (2014) (internal citations omitted) (“According to the National Alliance on Mental Illness (NAMI), 25 percent of adults have a ‘diagnosable mental disorder in a given year.’”).

common cause of death for individuals aged ten to twenty-four—and over ninety percent of suicides are carried out by individuals suffering from mental illnesses.⁴³ Of the millions of Americans who suffer from mental disorders yearly, nearly two-thirds fail to receive the necessary treatment, and these percentages increase drastically in children of ethnic and racial minorities.⁴⁴ Despite the prevalence of mental illness within American society, more than seventy percent of American adults believe that mental illnesses stem from “emotional weakness,” and sixty-five percent believe that it emanates from “bad parenting.”⁴⁵

The heavy toll that mental illness takes on American society is also present within the penal system. In fact, the U.S. Justice Department estimates that more than half of the inmates in prisons nationwide have a diagnosable mental disorder or exhibit similar symptoms.⁴⁶ Thus, the impact and extensiveness of mental illness in modern American society is axiomatic and is perceived in nearly every facet of society, be it the prisons⁴⁷ or the general population.⁴⁸ According to some estimates, mental illnesses have an even greater disease burden in “major market economies” than cancer does, and conditions such as schizophrenia, bipolar disorder, obsessive-compulsive disorder and depression are the *primary disabilities* amongst American and Canadian individuals aged fifteen to forty-four.⁴⁹

2. Mental Health Discrimination by Health Insurance Providers

Thankfully, modern medicine has progressed rapidly in the mental health sector. Generally, the mentally ill are now treated with respect by healthcare professionals and are no longer subject to bodily floggings, incarceration, or forced sterilization. Given the heavy burden that mental health conditions place on nearly every aspect of contemporary society, it seems logical that health insurance providers would be inclined to offer a wide array of mental health coverage, so as to incentivize individuals to enroll in their specific coverage plans. This would seemingly minimize costs for the individual and the health

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.* at 83.

⁴⁶ MARINI & STEBNICKI, *supra* note 26, at 38.

⁴⁷ Olga Khazan, *Most Prisoners Are Mentally Ill*, THE ATLANTIC (Apr. 7, 2015), <http://www.theatlantic.com/health/archive/2015/04/more-than-half-of-prisoners-are-mentally-ill/389682/> (explaining that “more than half of all inmates in jails and state prisons have a mental illness of some kind . . .”).

⁴⁸ VANSICKLE-WARD, *supra* note 42.

⁴⁹ JULIE ROVNER, HEALTH CARE POLICY AND POLITICS A TO Z 168 (3d ed. 2009).

insurance provider, and additionally mitigate the effects that prolonged and untreated mental illnesses have on the individual and society generally.

Unfortunately, this is not the case. Most health insurance providers—particularly before the ACA was signed into law—offered unlimited coverage for medical ailments, yet restricted mental health coverage to no more than twenty or thirty days per year.⁵⁰ Additionally, mental health copayments were often significantly larger than copayments for medical coverage—sometimes thirty percent higher.⁵¹ There are many theories and rationalizations justifying this disparity in coverage, most notably the “adverse selection theory.” The adverse selection theory states that in a market which fails to mandate parity in coverage, infirm individuals—who require the most comprehensive and expensive types of coverage—will flock to insurance plans that provide the requisite coverage, thus raising costs on all of the insureds, prompting healthy individuals to leave the plan and seek cheaper coverage options.⁵² Thus, health insurance providers face extreme market-based pressures to find ways to separate these “higher risk subscribers” from the “lower risk subscribers” in an attempt to keep premiums lower and attract healthier individuals, all of which will increase their profits.⁵³ Therefore, to increase their bottom lines, the adverse selection theory provides that health insurance providers will enact plans with limited coverage options, which will force “higher risk” individuals—such as those suffering from mental illnesses—to turn elsewhere.⁵⁴

Ultimately, although health insurance providers may not be innately prejudiced against mentally ill individuals, enacting plans that severely limit access to mental health coverage has the same inequitable effect. Absent any regulation to the contrary, health insurance providers are given far too much volition to enact extremely

⁵⁰ *Id.*

⁵¹ *Id.* (explaining that patients are often forced to pay half of an outpatient visit for mental health services, but only twenty percent of the services for outpatient medical/hospital visits).

⁵² Beth Mellen Harrison, *Recent Development: Mental Health Parity*, 39 HARV. J. ON LEGIS. 255, 269 (2002) (discussing how adverse selection may contribute to the inequities in mental health insurance coverage).

⁵³ Jennifer Arlen, *Contracting Over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 1013 (2010) (explaining that insurance providers “face strong market pressures to break out of the pooling equilibrium by finding ways to separate low-risk from high-risk subscribers” because such providers “stand to gain from segmenting the market”).

⁵⁴ *See id.* (contending that insurance providers often “seek other mechanisms to separate healthy from ill subscribers”).

limiting plans, which often have the effect of discriminating against mentally ill individuals, many of whom are impoverished.⁵⁵ These disparities in healthcare coverage indubitably create extreme hardships for those suffering from mental health conditions, and there are numerous cases that illustrate these hardships in practice.

It is critical to note, however, that the two cases discussed in the next two sections were both decided before the United States Supreme Court upheld Congress' power to pass and implement the ACA,⁵⁶ and are intended only to convey the disparity in coverage experienced by the parties involved.

i. *Edgar v. MVP Health Plan, Inc.*

In *Edgar v. MVP Health Plan, Inc.*, the plaintiff, Michael Edgar, suffered from depression, suicidality, and major depressive disorder.⁵⁷ Edgar began receiving psychiatric treatments to address his various mental conditions, including shock therapy, yet he did not receive relief from his symptoms after exhausting many of the traditional remedies.⁵⁸ Edgar, then, in conjunction with his treating psychiatrist and therapist, discovered the Menninger Clinic in Texas, which offered a seven-week inpatient program that treated adults with similar mental conditions.⁵⁹ Edgar's health insurance provider ("MVP") informed him that it would cover inpatient mental health treatments only when they were "medically necessary and manageable."⁶⁰ MVP then informed Edgar's father that they had no suitable inpatient facility for him to attend, and that if he experienced another crisis he should simply proceed to the local emergency room, from which the emergency room physicians would likely place him into a mental health ward.⁶¹ MVP allegedly failed to subsequently provide Edgar with any inpatient facility that would address his mental health disorders and be covered under his healthcare plan.⁶²

Seeing no viable alternative, Edgar began treatment at the

⁵⁵ See generally Antony B. Clapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 824 (1993) (discussing how individuals who are involuntarily committed to psychiatric institutions tend to be poor).

⁵⁶ See generally Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

⁵⁷ *Edgar v. MVP Health Plan, Inc.*, No. 1:09-cv-700 (GLS/DRH), 2011 U.S. Dist. LEXIS 49538, at *9 (N.D.N.Y. May 6, 2011).

⁵⁸ *Id.* at *7.

⁵⁹ *Id.*

⁶⁰ See *id.*

⁶¹ See *id.* at *8.

⁶² *Id.*

Menninger Clinic and was discharged several weeks later.⁶³ Upon his discharge and a physical examination, Edgar was found by Dr. Bettina Cardus to be a “physically stable young man,” who had gained “significant benefit from individual and group psychotherapies.”⁶⁴ Despite this, MVP refused to reimburse the clinic for Edgar’s treatments because of Edgar’s failure to attend an in-network facility⁶⁵—even though they had never provided him with the name of even one such institution.⁶⁶ Edgar eventually sued MVP under existing parity laws, yet the court found for MVP, stating, *inter alia*, that the treatment received by Edgar at the Menninger Clinic was not “medically necessary,” and the therapies were not “rendered in the most efficient and economical way.”⁶⁷

ii. *Hirsh v. Boeing Health & Welfare Benefit Plan*

In *Hirsh v. Boeing Health & Welfare Benefit Plan*, the plaintiff, Joel Hirsh, was employed by the Boeing Company, and as such was covered by their health insurance plan (“Boeing Health Insurance”) along with his spouse and children.⁶⁸ Hirsh’s son, A.H., had been receiving psychiatric treatments since he was a young child. As a teenager, A.H. received inpatient treatment at the Innercept Academy in Idaho, before being transferred to the King George School in Vermont, to help treat his various psychiatric conditions.⁶⁹ While A.H. was at the Innercept Academy, Boeing Health Insurance refused to continue reimbursing the facility, as it felt that A.H. no longer met its criteria for being treated at an inpatient facility.⁷⁰

This evaluation contrasted sharply with the view of Dr. Ullrich, A.H.’s attending physician, who was gravely concerned that A.H. would resume his use of illegal narcotics and relapse if he were to be released too early from the Innercept Academy.⁷¹ Despite Dr. Ullrich’s medical opinion and related concerns, Boeing Health Insurance nevertheless refused to reimburse the King George School for any of the treatments that it administered to A.H. and agreed only to pay a small percentage

⁶³ See *Edgar*, 2011 U.S. Dist. LEXIS 49538, at *9–10.

⁶⁴ *Id.* at *11–12.

⁶⁵ See *id.* at *12–13.

⁶⁶ *Id.* at *8.

⁶⁷ *Id.* at *17.

⁶⁸ *Hirsh v. Boeing Health & Welfare Benefit Plan*, 943 F. Supp. 2d 512, 514 (E.D. Pa. 2010).

⁶⁹ See *id.* at 514–15.

⁷⁰ *Id.* at 523.

⁷¹ *Id.*

of the fees to the Innercept Academy.⁷² Boeing Health Insurance pointed to the Mental Health and Substance Abuse portion of A.H.'s plan, under which treatment received needed to be "medically necessary" and affiliated with Boeing Health Insurance's plan in order to be reimbursable.⁷³ The court ultimately forced Boeing Health Insurance to reimburse the Innercept Academy for some of the outstanding charges, on the grounds that a reviewing court has the right to "overturn an administrator's decision to deny benefits if it is without reason or unsupported by substantial evidence."⁷⁴

III. STATE AND FEDERAL REACTIONS TO GROWING NATIONAL DEMANDS FOR MENTAL HEALTH PARITY IN INSURANCE COVERAGE

Due to the ubiquitous discrimination on behalf of health insurance providers against mentally ill individuals such as Michael Edgars and A.H., by the time the MHPAEA was enacted, nearly every state had already passed some form of mental health parity law.⁷⁵ It is critical to understand how some of the states attacked this issue in order to comprehend precisely why the MHPAEA fails to achieve its objective of ensuring mental health parity, and why it requires serious overhaul.

A. *Recognition of the Disparity in Coverage at the Highest Levels of the Federal Government*

The inequities experienced by both Michael Edgar and A.H. are merely two examples of how health insurance providers treat their insureds suffering from mental health conditions, and how the existing loopholes in federal parity legislation allow many providers to perpetuate these industry-wide behaviors. Imagine, hypothetically, that Edgar was suffering from congenital heart failure, instead of depression, suicidality, and major depressive disorder. If Edgar had received treatment at a top-notch cardiac facility, would the court have upheld the contentions of the health insurance provider, that the treatments were "not medically necessary," and that they were not "rendered in the most efficient and economical way," and therefore

⁷² *Id.* at 515.

⁷³ *Id.* at 520.

⁷⁴ *Hirsh*, 943 F. Supp. 2d at 524–25.

⁷⁵ Justin C. Wilson, *Congress's Second Attempt at Ending Discrimination Against Mental Illness: The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008*, 3 ST. LOUIS U. J. HEALTH L. & POL'Y 343, 372 (2010) ("By the time the 110th Congress passed the MHPAEA, nearly every state had enacted some form of mental health parity law.").

not reimbursable? Likely not. Granted, there are obvious differences between physical and mental diseases, such as the fact that physical maladies can often be detected through conventional measures, including an x-ray or magnetic resonance image, whereas mental illnesses cannot usually be detected using similar techniques. This does not make mental illnesses any less debilitating, however, to those who are suffering from them. On a societal level, mental illnesses pose not only a danger to those inflicted, but have additionally been linked to mass killings of civilians, although, admittedly, there have been conflicting studies regarding this correlation.⁷⁶ Although mental and physical illnesses are not screened for or treated in the same way, it is undisputable that mental illnesses can be devastating, and are pervasive among the American population.⁷⁷

These discriminatory cases simply accentuate one basic premise—that health insurance providers give less credence to mental health conditions than they do to physical ones, likely due to the increase of their bottom line, which leads to discriminatory treatment against those suffering from the former. While it is incontrovertible that mental and physical diseases are different from one another in a myriad of ways, this still does not give license to health insurance providers to discriminate against those suffering from the former on those grounds. In fact, this discrimination is what the MHPAEA explicitly aims to obliterate.

Additionally, much of the discrimination issue boils down to health insurance providers' determination of when a mental health condition qualifies as an insurable "medical necessity." As delineated ad nauseam, there are an infinite number of differences between physical ailments and mental health conditions, and health insurance providers face the increasingly intricate task of deciding when such

⁷⁶ Steve Kroft, *Untreated Mental Illness an Imminent Danger?*, CBS NEWS (Jan. 14, 2016, 12:41 PM), <http://www.cbsnews.com/news/untreated-mental-illness-an-imminent-danger/> (explaining that several recent mass shootings have been carried out by the mentally ill, and that this is the symptom of a "failed mental health system," which often doesn't treat the mentally ill properly until a judge decides that the individual represents an "imminent danger to themselves or others"). *But see Response Letter to CBS 60 Minutes*, MENTAL HEALTH ASS'N OF NEB. (Aug. 23, 2016, 2:40 PM), <http://www.mha-ne.org/response-letter-to-cbs-60-minutes/> (stating that the correlation between mental illness and mass shootings is "far from accurate" and that "[o]ne survey of mass shootings between 2009 and 2013 found that perpetrators had a known mental health condition in only 11 percent of these incidents").

⁷⁷ RICHARD J. McNALLY, *WHAT IS MENTAL ILLNESS?* 1 (2011) (describing that more than half of all Americans will suffer from mental illness at some point within their lives, and that a quarter of Americans will have suffered from mental illness within the last year alone).

conditions will qualify for coverage. Although the issue of determining when specific treatments are “medically necessary” and parity in health insurance coverage overlap to a large extent, they are still two distinct problems, and this Comment does not intend to address the former, nor attempt to solve it.

Due to this resounding inequity in treatment, however, the American public’s attention has recently shifted towards a demand for parity in the treatment of mental illnesses.⁷⁸ The shift is evidenced by President George W. Bush’s Freedom Commission on Mental Health in 2003,⁷⁹ under which he assembled a group of renowned scientists and mental health professionals. The President mandated that the group study the current system and devise a plan that would enable the mentally ill to receive the treatment that they deserve, devoid of the existing inequities in private health insurance plans, thus allowing them to “participate fully in their communities.”⁸⁰ The Commission recognized the unfair practices in mental health insurance coverage, and further discovered that mental illnesses are extremely common and affect almost every American family.⁸¹

The Commission additionally disclosed that mental illness can occur at any stage of life, and that no community is unaffected by mental illnesses: “no school or workplace is untouched.”⁸² With regard to the economy, the Commission exposed that the indirect costs of mental illness are estimated to be \$79 billion.⁸³ Approximately \$63 billion stems from the loss of labor force productivity due to the mental

⁷⁸ See generally Letter from Michael F. Hogan, Chairman, President’s New Freedom Comm’n on Mental Health, to George W. Bush, President of the United States (July 22, 2003), <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/ExecSummary.pdf> (discussing how the American populace “[u]nderstand[s] that [m]ental health [i]s [e]ssential to [o]verall [h]ealth,” and further that under a “transformed system, Americans will seek mental health care when they need it—with the same confidence that they seek treatment for other health problems”).

⁷⁹ See *id.*

⁸⁰ The letter states, in relevant part, that:

The mission of the Commission shall be to conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system. The Commission’s goal shall be to recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities.

Id.

⁸¹ *Id.* at 2.

⁸² *Id.*

⁸³ *Id.* at 4.

illnesses, \$12 billion in mortality costs from premature death, and almost \$4 billion in productivity losses for imprisoned persons.⁸⁴ In fact, the Commission suggested that stricter parity regulation would significantly reduce these overwhelming societal costs.⁸⁵

1. State-Enacted Parity Laws

Due to the prevalence of the discrimination against the mentally ill by health insurance providers, today, almost every single state has enacted some type of parity law, with the hopes of dissolving the inequity in treatments, and health insurance coverage generally.⁸⁶ While similar themes are expressed throughout the majority of these state parity laws, states have adopted varying approaches with regard to how they attack the inequitable practices by health insurance providers.

i. The State of Georgia

In its healthcare parity legislation, Georgia defines a “mental disorder” as it is interpreted by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM),⁸⁷ which is a manual promulgated by the American Psychiatric Association listing and classifying all known mental disorders. The law generally requires that any health insurance provider that offers health coverage of any sort⁸⁸ must additionally provide mental health coverage for the plan’s beneficiaries.⁸⁹ The law further necessitates that annual/lifetime dollar limits and deductibles must be the same for mental health and physical health.⁹⁰ Admittedly, however, the law does allow for numerical limits⁹¹ on inpatient and

⁸⁴ See *id.*

⁸⁵ See *infra* pp. 28–29.

⁸⁶ See generally Richard Cauchi & Karmen Hanson, *Mental Health Benefits: State Laws Mandating or Regulating*, NAT’L CONF. OF ST. LEGISLATURES (Dec. 30, 2015), <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> (giving a general overview of the parity laws that exist in each state).

⁸⁷ GA. CODE ANN. § 33-24-29(a)(2) (1998).

⁸⁸ See § 33-24-29(a)(1)(A)–(F) (explaining that an “[a]ccident or sickness benefit plan” includes group accident and sickness insurance policies that are issued within the state, a group contract issued by a health care plan, group contracts issued by health maintenance organizations, and any other “similar group accident and sickness benefit plan”).

⁸⁹ § 33-24-29(c).

⁹⁰ *Id.*

⁹¹ See *id.* (stating that health insurance providers can provide for “different limits on the number of inpatient treatment days and outpatient treatment visits,” meaning, for example, that the health insurance provider can legally decide to only reimburse a psychologist for ten visits annually, even if visits to one’s primary care physician are unlimited).

outpatient mental health treatments.⁹²

ii. The State of Connecticut

Similar to Georgia, Connecticut also defines a “mental condition” as any disorder included in the most updated edition of the DSM.⁹³ Unlike Georgia’s law, however, Connecticut limits the list of conditions that health insurance providers might otherwise be forced to cover, given that the DSM lists hundreds of different illnesses. The law therefore lists seven specific conditions, such as “communication disorders” and “caffeine-related disorders,” which are not included as coverable mental conditions.⁹⁴ The law then attempts to ensure parity in healthcare coverage in other ways as well, including mandating that insurance companies not place a greater “financial burden” on mental health benefits than they do for medical benefits.⁹⁵ The law further dictates that if licensed physicians can be reimbursed under the plan, so can psychologists.⁹⁶

iii. The State of New York (Timothy’s Law)

In terms of defining a “mental condition,” New York takes a significantly different approach than Georgia and Connecticut. New York defines a mental health condition as one that stems from a “biological disorder of the brain,” and that further “substantially limits the functioning” of the individual suffering from the condition.⁹⁷ The state law then lists several conditions that are included in this

⁹² *Id.*

⁹³ CONN. GEN. STAT. § 38a-488a(a) (2012) (“For the purposes of this section, ‘mental or nervous conditions’ means mental disorders, as defined in the most recent edition of the American Psychiatric Association’s ‘Diagnostic and Statistical Manual of Mental Disorders.’”).

⁹⁴ Connecticut law dictates that the following are not included as mental or nervous conditions:

(1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”

Id.

⁹⁵ § 38a-488a(b) (“No such policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions.”).

⁹⁶ § 38a-488a(c).

⁹⁷ 2006 N.Y. Laws 748.

definition, such as schizophrenia, depression, and anorexia.⁹⁸ The law also requires that any insurance plan which makes available coverage for inpatient hospital care must additionally provide coverage for the “diagnosis and treatment of mental, nervous, or emotional disorders.”⁹⁹

2. Federally Enacted Parity Law: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This Comment will focus on the principal federally enacted parity law; namely, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).¹⁰⁰ The MHPAEA applies to group health plans,¹⁰¹ and allows health insurance providers to define “mental illness” on their own, so long as the definition comports with relevant state and federal laws.¹⁰² The MHPAEA mandates that the financial requirements applied to mental health and substance abuse benefits, such as copayments and deductibles, not be more restrictive than the financial requirements for medical and surgical coverage.¹⁰³ The MHPAEA also ensures that if out-of-network providers are permitted for medical and surgical coverage, then the plan must designate out-of-network providers for mental health and substance abuse benefits as well.¹⁰⁴ The MHPAEA then instructs that treatment limitations for mental health benefits cannot be any more restrictive than they are for medical and surgical benefits.¹⁰⁵ Treatment

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ See generally Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 100-343, §§ 511–12, 122 Stat. 365 (codified as amended at 29 U.S.C. § 1185a (2012) & 42 U.S.C. § 300gg-26 (2012)). It should be noted that the MHPAEA amended and expanded upon an existing law, namely the Mental Health Parity Act of 1996, which will not be discussed at length in this Comment. See also *Mental Health and Substance Use Disorder Parity*, U.S. DEP’T OF LAB., <https://www.dol.gov/ebsa/mentalhealthparity/> (last visited Sept. 19, 2016).

¹⁰¹ See 29 U.S.C. § 1185a(a)(1) (2012).

¹⁰² § 1185a(e)(4) (“The term ‘mental health benefits’ means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.”).

¹⁰³ § 1185a(a)(3)(A)(i).

¹⁰⁴ § 1185a(a)(5) (“[I]f the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.”).

¹⁰⁵ § 1185a(a)(3)(A)(ii) (“[T]he treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical

limitations include the number of visits allowed, caps on the number of treatments, and other similar confines.¹⁰⁶

The MHPAEA also allows for two major exemptions. The first is the “Small Employer Exemption,” which essentially absolves a business from adhering to the mandates of the MHPAEA so long as it employed less than fifty employees during the preceding calendar year.¹⁰⁷ The second is the “Cost Exemption,” which states that if the total cost to the group health plan is raised by more than two percent in the first year, or by one percent in subsequent years, as determined by a licensed actuary, such a disadvantaged health group/plan will be immune from the directives of the MHPAEA.¹⁰⁸ It is likely that these exemptions were added to the act due to the powerful insurance lobby, whose demands eventually led to a diluted version of the original bill.¹⁰⁹ In fact, the influence of special interests groups regularly contributes to the vagueness of statutes in its final form.¹¹⁰ Additionally, unlike the ACA,¹¹¹ the MHPAEA did not mandate parity in coverage for individual health plans or small group market plans.

Lastly, it is critical to note that the MHPAEA mandates that if a health insurance provider refuses to proffer reimbursements for any mental health or substance abuse benefits, it is obligated to provide the beneficiary with an adequate reason for the denial.¹¹²

3. The Patient Protection and Affordable Care Act of 2010

The ACA accomplished much when it was signed into law in 2010, which included continuing the upwards trajectory that had been set in motion by the MHPAEA and many preceding state parity laws. It did so by mandating that all qualified health plans issued through the exchanges include an “essential health benefits package,”¹¹³ which

benefits covered by the plan.”).

¹⁰⁶ See Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE U. L. REV. 179, 210 (2013) (internal citations omitted) (“Treatment limitations ‘include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.’”).

¹⁰⁷ § 1185a(c)(1)(A–B).

¹⁰⁸ § 1185a(c)(2)(A–C).

¹⁰⁹ See Weber, *supra* note 106, at 193.

¹¹⁰ See VANSICKLE-WARD, *supra* note 42, at 98.

¹¹¹ 42 U.S.C. § 300gg-6(a) (2012).

¹¹² § 1185a(a)(4) (“The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits . . . shall, on request or as otherwise required, be made available . . . to the participant or beneficiary . . .”).

¹¹³ 42 U.S.C. § 18021(a)(1)(B) (2012).

comprises coverage for mental health conditions, substance abuse disorders, and behavioral health treatments.¹¹⁴ The ACA additionally required all health insurance providers offering health insurance coverage in individual or small group markets to include the essential health benefits package with the accompanying coverage for mental health and substance abuse conditions.¹¹⁵

What is therefore discernible is a clear upward trajectory in regard to federal and state legislation, which mandates that health insurance providers supply parity in the coverage. First, several states—including, *inter alia*, New York, Connecticut, and Georgia—began by requiring parity in coverage with varying levels and degrees of effectiveness. Then, in 2008, this was mirrored at the federal level by the enactment of the MHPAEA, though the act still allowed several types of plans to dodge the parity requirements.¹¹⁶ Subsequently, in 2010, the ACA required that all individual and small group health plans—which are defined as employers who have fifty or less employees¹¹⁷—include benefits for mental health and substance abuse conditions.¹¹⁸ What federal legislation still has yet to achieve is to mandate outright parity in health insurance coverage, with no exemptions or exceptions. Congress has taken gargantuan steps towards this objective, as evidenced by the increasingly strict parity-related statutes and regulations, but has yet to demand outright parity in coverage. Congress can accomplish this lofty aspiration, however, by amending the MHPAEA to close most of its loopholes and plug any existing gaps, and subsequently ratifying the ACA to include the newly amended MHPAEA. Prior to taking this action, it is imperative to clearly accentuate all of the current problems that plague the MHPAEA, and delineate the steps required to rectify them.

¹¹⁴ 42 U.S.C. § 18022(b)(1)(E) (2012) (stating that an “[e]ssential health benefits package” includes “[m]ental health and substance use disorder services, including behavioral health treatment[s]”).

¹¹⁵ 42 U.S.C. § 300gg-6(a) (2012).

¹¹⁶ See, for example, § 1185a(c)(1)(A–B) for the delineation of the “small employer exemption” which allows businesses with less than fifty employees to escape the mandates of the MHPAEA.

¹¹⁷ 42 U.S.C. § 300gg-91(e)(4–5) (2012) (defining “small employer” to mean an “employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year,” and subsequently defining “small group markets” as when “individuals obtain health insurance coverage . . . through a group health plan maintained by a small employer”).

¹¹⁸ 42 U.S.C. § 18022(b)(1)(E) (2012) (“[S]uch benefits shall include . . . [m]ental health and substance use disorder services . . .”).

IV. PROBLEMS WITH THE MHPAEA AND AMENDMENTS REQUIRED IN
ORDER TO ACHIEVE COMPLETE PARITY IN HEALTH INSURANCE
COVERAGE

The MHPAEA contains several defects, some of which stem from the fact that the law fails to go far enough in its parity requirements, and some of which are statutory exemptions in the law itself—both greatly weaken its overall effectiveness.¹¹⁹ The language used in many of the state parity laws, however, does not allow these legal loopholes to be perpetuated. If such language were incorporated into the MHPAEA, it would bring Congress closer to its stated objective of achieving genuine parity in healthcare coverage, by eliminating loose and arbitrary language, along with the two statutory exemptions. Individuals suffering from mental health conditions and substance abuse problems should not have to flock to certain states, like Georgia, that have enacted strict parity laws, and avoid others that have failed to follow suit. It is time for the federal government, by amending the MHPAEA and ratifying the ACA to include it, to finally adapt a uniform parity law that will be applicable in all states.

A. *Flaws in the MHPAEA*

1. MHPAEA Fails to *Require* Parity in Coverage

The first major defect with regard to the MHPAEA is that it fails to *mandate* universal parity in coverage by health insurance providers and employers with group health plans. The MHPAEA only requires that *if* an employer offers coverage for mental health and substance abuse disorders, and does not fall into the Small Employer or Cost Exemptions, *then* it is required to comply with the guidelines delineated throughout the remainder of the MHPAEA.¹²⁰ Thus, parity in healthcare coverage under the MHPAEA is only required in a very specific set of circumstances: when the business entity employs more than fifty individuals,¹²¹ *and* when the total cost to the group health plan is not increased by more than two percent or one percent in the

¹¹⁹ See Weber, *supra* note 106, at 207 (explaining that the Small Employer and Cost Exemptions created a lot of “uncertainty” in regard to how far health insurance providers must go to ensure parity in coverage).

¹²⁰ See 29 U.S.C. § 1185a(a)(1) (2012) (emphasis added) (stating that “[i]n the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits . . .”). Notice the emphasized conditional language.

¹²¹ § 1185a(c)(1)(A–B). See also *Coalition for Parity v. Sebelius*, 709 F. Supp. 2d 10, 13 (D.D.C. 2010).

first and second years of complying with the MHPAEA, respectively.¹²² An employer or health insurance provider can also, hypothetically, simply choose not to offer mental health or substance abuse benefits at all, in which case the MHPAEA has no control over them whatsoever (though subsequent legislation has made this extremely difficult,¹²³ if not impossible). This scenario can become nightmarish for mentally ill individuals in states like Wyoming, which currently have no mental health parity legislation.¹²⁴ In such states, all that mentally ill individuals have to depend on for anti-discrimination protections, is the MHPAEA. Although the ACA addressed some of these concerns, health insurance plans outside the scope of the ACA can still continue to implement extremely restrictive coverage for mental health and substance abuse benefits.

2. MHPAEA Fails to Provide Insurance Companies with Applicable Standards

The MHPAEA dictates that there must be parity between medical/surgical and mental health benefits, but neglects to give guidance as to how insurance companies are expected to abide by this. Many insurance companies and their subsidiary organizations, such as managed behavioral healthcare organizations, are concerned about this because they have little direction as how to engage in the comparisons between medical and mental health benefits—especially non-quantitative benefits.¹²⁵ Non-quantitative insurance benefits include issues such as medical necessity, preauthorization for experimental treatments, and exclusions to certain treatment options based on the patient's failure to complete a prerequisite form of treatment.¹²⁶

For example, if a patient suffered from a rare form of cancer and wanted his or her health insurance provider to cover a life-saving or innovative treatment, preauthorization would be required. Let's assume that this patient did in fact receive consent in this circumstance. If a different patient under the same plan, who suffered from an advanced form of schizophrenia, requested preauthorization for an experimental treatment and was denied consent, he or she

¹²² § 1185a(c)(2)(A–C).

¹²³ See *supra* notes 113–118 and accompanying text.

¹²⁴ See Ruffin Prevost, *Funding Mental Health is Challenge in State*, WYO. TRIBUNE EAGLE (Jan. 14, 2016, 10:18 PM), http://www.wyomingnews.com/news/article_24833102-f532-59ea-8476-98ec26792f8b.html (“Wyoming has never had a mental health parity law governing insurance providers, and its health insurance market is limited.”).

¹²⁵ See *Coalition for Parity*, 709 F. Supp. 2d at 15–16.

¹²⁶ 29 C.F.R. § 2590.712(c)(4)(ii)(A–H) (2012).

could sue the health insurance provider under the MHPAEA¹²⁷ for failing to ensure parity between mental health and medical coverage. Yet, how could a court possibly compare an experimental treatment for cancer, to an experimental treatment for a mental health condition such as schizophrenia? It is nearly impossible to conduct such an “apples-to-apples comparison” given the stark differences between mental and physical conditions, and their appropriate remedies.¹²⁸ The regulatory language that attempts to address this issue is obtuse, and rather unhelpful.¹²⁹

3. The MHPAEA Allocates Excessive Power to Health Insurance Providers by Failing to Define What Actually Constitutes a Mental Health Condition

Despite the fact that the MHPAEA requires that each health insurance provider adhere to relevant state parity laws, at the federal level, the MHPAEA provides health insurance providers with far too much discretion, in that it allows them to define “mental health benefits”¹³⁰ without providing any statutory obligations as to what must be considered a mental health condition. Thus, the MHPAEA provides health insurance providers with far too much leeway in deciding what constitutes a mental health condition, and whether coverage is subsequently required. It is critical to note that although the MHPAEA leaves much discretion to health insurance providers in regard to defining what constitutes a mental illness, the ACA curtailed this discretion significantly by requiring that all “qualified health plans” include an “essential health benefits package,”¹³¹ which includes

¹²⁷ *See id.*

¹²⁸ *See Weber, supra* note 106, at 246–47.

¹²⁹ The regulations state, in relevant part, that:

A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

29 C.F.R. § 2590.712(c)(4) (2012).

¹³⁰ 29 U.S.C. § 1185a(e)(4) (2012) (emphasis added) (“The term ‘mental health benefits’ means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal *and* State law.”).

¹³¹ 42 U.S.C. § 18021(a)(1)(B) (2012).

“[m]ental health and substance disorder services.”¹³² Subsequent regulations further require that in order to comply with these statutory mandates, health insurance providers must choose a “benchmark plan,”¹³³ which usually ensures that there is at least decent coverage for mental health benefits. Nonetheless, the MHPAEA can still be amended to fill any of the discretionary gaps remaining, considering that the ACA is subsequently ratified with the amended version.

B. Amendments to the MHPAEA That Should Be Enacted, Which Will Bring the Act Closer to its Stated Objective of Complete Parity in Healthcare Coverage

While nearly every state has currently enacted healthcare parity laws, approaches have varied widely. There are three specific mechanisms utilized by some states in this regard, that if implemented as part of the MHPAEA, would bolster it exponentially. First, the MHPAEA should mirror Georgia’s parity law, in that it should *require* health insurance providers to offer mental health coverage if they offer coverage for physical health. Second, the MHPAEA should echo statutory language utilized by Connecticut and Utah, which use the DSM as the basis for defining a “mental illness.” Lastly, the MHPAEA should list specific exceptions to conditions that are otherwise included in the DSM, as do Connecticut and Utah in their respective laws.

1. The MHPAEA Should Mimic Georgia’s State Parity Law and Require that Health Insurance Companies Provide Mental Health and Substance Abuse Coverage

Georgia’s parity law, similar to the ACA, mandates that any health insurance provider that provides medical coverage *must also* make mental health coverage available.¹³⁴ This leaves health insurance providers with only one option: to either make available mental health coverage to plan beneficiaries, or to not offer any type of coverage at

¹³² 42 U.S.C. § 18022(b)(1)(E) (2012).

¹³³ 45 C.F.R. § 156.110(a)(5) (2015) (“An EHB-benchmark plan must meet the following standards . . . [m]ental health and substance use disorder services . . .”).

¹³⁴ Georgia’s law states, in relevant part, that:

Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed on or after July 1, 1998, coverage for the treatment of mental disorders.

GA. CODE ANN. § 33-24-29(c) (1998).

all. This assertive mandate should replace the “if you offer it, then parity is required” language, which is currently in the MHPAEA.¹³⁵ Not including such obligatory language in the statute only reinforces the stigma that those who suffer from mental illnesses are emotionally weak¹³⁶—otherwise the statute would consider mental health conditions as seriously as it might cardiomyopathy, or any other physical ailment.

Any arguments which proffer that mental health illnesses are somehow dissimilar in that they are diagnosed differently from physical maladies, and that they cannot truly be “cured,” are ill-conceived for two reasons. First, almost every medical condition is diagnosed in a unique and exclusive manner. Just because a colonoscopy detects cancerous polyps,¹³⁷ and a mammogram discovers breast cancer,¹³⁸ does not discredit either disease. Every ailment must be approached and diagnosed in a manner custom-tailored to that disease, and because of that, the manner of diagnosis should be irrelevant in regard to mandating parity in healthcare coverage. It is undisputed that mental health conditions are accompanied by their diagnostic difficulties, since, for example, schizophrenia cannot be prodded and nudged in the same manner that a doctor could a laceration, or a distended bowel. This should not, however, provide health insurance providers with the right to offer disparities in coverage, should they wish to do so. Secondly, there are dozens of diseases, such as lupus and Parkinson’s, which cannot currently be cured. Yet, health insurance providers almost universally cover available treatments for these diseases. So even if a particular mental illness is not entirely curable, health care providers should be mandated to cover treatments for them, alongside all of the similar physical illnesses, if true parity is to be obtained. Mandating universal coverage for mental health conditions is also supported by other

¹³⁵ See, e.g., 29 U.S.C. § 1185a(a)(3)(a) (2012).

¹³⁶ See Maria A. Morrison, *Changing Perceptions Of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 9 (2000) (“A recent survey found that seventy-one percent of the general population thought that mental illness resulted from an emotional weakness.”).

¹³⁷ *Frequently Asked Questions About Colonoscopy and Sigmoidoscopy*, AM. CANCER SOC’Y, <http://www.cancer.org/healthy/findcancerearly/examandtestdescriptions/faq-colonoscopy-and-sigmoidoscopy> (last visited Feb. 2, 2016) (explaining that colonoscopies detect precancerous polyps within the colon and rectum).

¹³⁸ *American Cancer Society recommendations for early breast cancer detection in women without breast symptoms*, AM. CANCER SOC’Y, <http://www.cancer.org/cancer/breast-cancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-ac-recs> (last visited Feb. 2, 2016) (explaining that mammograms can help to detect breast cancer at an early stage).

recent legislation, namely the ACA, which necessitates that individual and small group market plans cover “essential health benefits,” which include mental health and substance abuse disorders.¹³⁹

i. Central Argument Against Requiring Mental Health Coverage

The principal argument raised by insurance companies in regard to legally mandated mental health insurance coverage mainly involves issues of expense.¹⁴⁰ Many insurance companies posit that a parity mandate would exponentially increase costs—due to their greatly expanded fiscal liabilities—which in turn would likely be passed onto the plan’s beneficiaries, via higher premium costs.¹⁴¹ They additionally opine that higher costs for employers might even result in lower salaries and bonuses to compensate for their losses.¹⁴²

ii. Response: Mandating Parity in Coverage Will *Not* Dramatically Raise Prices for Insurance Companies, and May Even Boost the Economy Generally

a. Necessitating Parity in Coverage Will Not Lead to Additional Significant Costs

Many health insurance providers released heated rhetoric when the MHPAEA was passed, worried that if they were mandated to offer parity in healthcare coverage, their costs would rise exorbitantly—some insurance companies projected that they would be confronted with annual increases of between fifteen to twenty-five percent.¹⁴³ When analyzed by nonpartisan entities, however, such as the Congressional Budget Office, these conjectures were proven to be nothing other than hyperbolic sophistries. This is abundantly evident in the Congressional Budget Office’s appraisal, which estimated that mandating parity in healthcare coverage would raise premiums by less

¹³⁹ 42 U.S.C. § 18022(b)(1)(E) (2012); *see also* Michael C. Barnes & Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatments for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 576–77 (2014).

¹⁴⁰ *See generally* Christopher John Churchill, *The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Federal Legislation*, 44 GA. L. REV. 511, 527–28 (2010) (explaining that critics of a parity mandate aver that increased costs by health insurance providers would force employers to “pass them on to employees or reduce coverage,” in addition to causing “lower salaries and job reductions because employers may not be able to afford to pay as much to as many employees”).

¹⁴¹ *See id.*

¹⁴² *See id.*

¹⁴³ *See* ROVNER, *supra* note 49, at 169.

than *one percentage point*.¹⁴⁴ This calculation was bolstered by analyzing the more than twenty states that had adopted parity laws prior to the MHPAEA, in most of which the costs had not risen by more than one percent.¹⁴⁵ In fact, no state that has ever enacted a healthcare parity law has subsequently repealed it due to costs, or any other consideration.¹⁴⁶

In fact, the regulations state that, based on the reports by numerous agencies, there is little evidence to suggest that the implementation of the MHPAEA will negatively impact health insurance providers in a fiscal manner.¹⁴⁷ These regulations further clarify that only a miniscule percentage of health insurance providers have stopped providing mental health or substance abuse benefits due to the enactment of the MHPAEA, and for plans that did drop such benefits, there is no indication that it had anything to do with the passage of the MHPAEA.¹⁴⁸ Critically, the regulations indicate that after 2011, which was the first year in which the interim final regulations for the MHPAEA were effective, there was no meaningful upturn in spending for behavioral health.¹⁴⁹

b. Mandating Parity May Even Assist the Economy

Requiring parity in healthcare coverage will also grant much needed financial protections to the general public.¹⁵⁰ This is due to the fact that seventeen percent of bankruptcies nationwide stem from unpaid healthcare bills.¹⁵¹ Of those medical bankruptcies, nearly ten percent are attributed to mental health costs, and an additional two to three percent are credited to drug and substance abuse disorders.¹⁵² Therefore, by mandating that all individuals nationwide are in fact covered for mental health conditions, a parity law of this nature will prevent numerous bankruptcies from occurring, which will benefit the economy at large in an incontestably positive manner.¹⁵³ Furthermore,

¹⁴⁴ *Id.* (emphasis added).

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ See Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68255 (Nov. 13, 2013).

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ See *generally* Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68258 (Nov. 13, 2013).

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ See *id.*

it has been established that certain mental health conditions, such as depression, cause annual losses of productivity to the tune of \$31 billion to \$51 billion.¹⁵⁴

President Bush's Freedom Commission on Mental Health provided even higher estimates, claiming that mental health conditions have a detrimental impact on the economy to the tune of \$79 billion per annum.¹⁵⁵ In fact, mental health conditions are proven to cause more missed days of work than numerous other medical conditions, including diabetes and lower back pain.¹⁵⁶ Additionally, psychiatric disability is the *most prevalent* type of disability on the social security benefit rolls.¹⁵⁷

Therefore, authorizing mandatory mental health coverage will have two exceedingly positive results: it will prevent numerous bankruptcies from occurring, and keep labor force participants employed, provided that mentally ill individuals utilize their benefits and seek treatment. Even for chronic mental illnesses, insurance coverage will greatly lower out-of-pocket costs, which leads to financial stability and less bankruptcy filings. All of this will have a tremendously propitious impact on the economy, which will likely compensate for the possibility of a slight percentage increase in premium rates.

c. Mandating Coverage at the Federal Level is
Constitutional under the Commerce Clause

Although this Comment does not intend to conduct an extensive constitutional analysis, it deserves a mention given the broad nature of this recommended amendment to the MHPAEA. It is a fundamental tenet of constitutional law that Congress only has the power to enact laws that fall within its constitutionally enumerated powers, as delineated in Article I, Section 8 of the U.S. Constitution.¹⁵⁸ Generally, anything not specifically allocated to Congress and the remaining two branches of government is left to the states, as per the Tenth Amendment.¹⁵⁹ This has long been interpreted to mean that the states

¹⁵⁴ *Id.*

¹⁵⁵ *See generally* Letter from Michael F. Hogan, Chairman, President's New Freedom Comm'n on Mental Health, to George W. Bush, President of the United States (July 22, 2003), <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/ExecSummary.pdf> ("In the U.S., the annual economic, indirect cost of mental illnesses is estimated to be \$79 billion.").

¹⁵⁶ Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68258 (Nov. 13, 2013).

¹⁵⁷ MARINI & STEBNICKI, *supra* note 26, at 39.

¹⁵⁸ *See* U.S. CONST. art. I, § 8.

¹⁵⁹ U.S. CONST. amend. X.

can enact any law that pertains to the health, safety, and welfare of its citizens,¹⁶⁰ which has extremely broad applications. Therefore, the numerous state parity laws are undoubtedly constitutional, given that they pertain to the health, safety, and welfare of their citizens.

In order for Congress to mandate that all health insurance providers nationwide offer mental health coverage, it would need to link such a law to one of its constitutionally enumerated powers. In this case, Congress would likely be able to connect this mandate to the Commerce Clause.¹⁶¹ In the landmark case of *Wickard v. Filburn*, the Supreme Court of the United States clarified that Congress has the power to regulate anything that “exerts a substantial economic effect on interstate commerce.”¹⁶² In 2014, Americans spent nearly three trillion dollars on healthcare costs, or almost ten thousand dollars per person.¹⁶³ This amounts to more than seventeen percent of America’s Gross Domestic Product.¹⁶⁴ Healthcare—in which mental health conditions play a huge role—would therefore certainly be considered by the Supreme Court to have a “substantial economic effect.”¹⁶⁵

Additionally, individuals often cross state lines in order to see a medical specialist or have specific procedures performed. This phenomenon was evident in *Edgar v. MVP Health Plan, Inc.*, in which the plaintiff, a New York native, sought treatment for his mental health conditions in Texas.¹⁶⁶ Similarly, in *Hirsh v. Boeing Health & Welfare Benefit Plan*, the plaintiff sought treatment for his mental health conditions in both Idaho and Vermont.¹⁶⁷ Healthcare therefore indubitably affects interstate commerce, thus qualifying for linkage to the Commerce Clause, as per the Supreme Court’s precedent in *Wickard*. Hence, it is extremely likely that a proposed amendment to the MHPAEA or the rephrasing of its language and diction, would survive constitutional scrutiny.

Critically, in *National Federation of Independent Business v. Sebelius*,

¹⁶⁰ See *Dep’t of Revenue v. Davis*, 553 U.S. 328, 340 (2008).

¹⁶¹ U.S. CONST. art. I, § 8, cl. 3 (establishing that Congress has the power to “regulate commerce with foreign nations, and among the several states, and with the Indian tribes”).

¹⁶² *Wickard v. Filburn*, 317 U.S. 111, 125 (1942).

¹⁶³ *Historical*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealth-expenddata/nationalhealthaccountshistorical.html> (last visited Feb. 2, 2016).

¹⁶⁴ *Id.*

¹⁶⁵ See *id.*

¹⁶⁶ *Edgar v. MVP Health Plan, Inc.*, No. 1:09-cv-700 (GLSDRH), 2011 U.S. Dist. LEXIS 49538, at *7 (N.D.N.Y. May 9, 2011).

¹⁶⁷ *Hirsh v. Boeing Health & Welfare Benefit Plan*, 943 F. Supp. 2d 514, 515 (E.D. Pa. 2010).

the United States Supreme Court held that the individual mandate in the ACA was outside the realm of the Commerce Clause, and thus Congress did not have the power to enact the ACA by linking it to that particular power.¹⁶⁸ Mandating parity in health insurance coverage is distinguishable from this holding, however, since the law would not mandate that people actually *buy* insurance, but rather is only instructive as to what types of insurance plans must be made available by eligible providers.

2. The MHPAEA Should Follow the Examples of Connecticut and Utah by Utilizing the DSM to Set the Boundaries of What Constitutes a Mental Disorder with Specific Statutory Exceptions

Several state parity laws currently use the DSM to define which mental conditions must be covered by health insurance providers in their respective states.¹⁶⁹ Other states, such as Connecticut and Utah, perhaps acknowledging the expansive nature of the DSM, additionally list specific mental health conditions that health insurance providers are not mandated to cover, even if they are listed in the DSM.¹⁷⁰ For example, Connecticut's health parity law uses the DSM to define the coverable "mental and nervous conditions," but then lists several specific disorders that insurance companies are not mandated to cover, despite their inclusion in the DSM.¹⁷¹ Such conditions include: intellectual disabilities; motor disorders; communication disorders; and caffeine-related disorders.¹⁷² This method is also utilized in Utah's mental health parity law.¹⁷³ Utah, like Connecticut, uses the DSM to define which mental conditions must be covered by health insurance providers,¹⁷⁴ and then specifically lists disorders that are not included in the coverable conditions, which include: marital problems; psychosexual disorders; personality disorders; and chronic adjustment disorders.¹⁷⁵

¹⁶⁸ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2593 (2012).

¹⁶⁹ See generally CONN. GEN. STAT. § 38a-488a (2012); UTAH CODE ANN. § 31A-22-625 (LexisNexis 2000).

¹⁷⁰ See § 38a-488a; § 31A-22-625.

¹⁷¹ § 38a-488a.

¹⁷² *Id.*

¹⁷³ See generally § 31A-22-625.

¹⁷⁴ § 31A-22-625(1)(d)(i).

¹⁷⁵ See § 31A-22-625(1)(d)(ii) (stating that the following are not included as a "mental health condition," if they are the "primary or substantial reason" that treatment is sought: "a marital or family problem; a social, occupational, religious, or other social maladjustment; a conduct disorder; a chronic adjustment disorder; a psychosexual disorder; a chronic organic brain syndrome; a personality disorder; a

The MHPAEA would be greatly strengthened by adapting a similar model, as it would eradicate one of the major existing loopholes within the legislation. Under the current enactment, the MHPAEA allows health insurance providers themselves to define—within state law and subsequent federal law parameters—what actually constitutes a mental health condition.¹⁷⁶ Thus, even if health insurance providers were mandated to cover mental health conditions generally, a provider could simply have a very limited assortment of conditions that they would define as “mental health conditions,” and thus largely escape the mandates of the MHPAEA. By requiring that all insurance companies utilize the most recent edition of the DSM as a source for the definitions of mental health conditions, health insurance providers could no longer refuse coverage simply because *they* have not defined a particular condition to be a coverable mental health disorder. Rather, if the condition is listed in the DSM and is not subject to a specific congressional exemption, the health insurance provider would be mandated to cover it.

i. Key Arguments Against Using the DSM as the Source for
Mental Health Disorders

a. The DSM is Too Lengthy and Consists of Too Many
Questionable Conditions

Those opposed to utilizing the DSM as a universal source for mental health disorders in regard to insurance coverage, often refer to the fact that the DSM simply lists too many conditions, and is thus unfeasible and unrealistic in such a scenario.¹⁷⁷ One of the recent editions of the DSM lists 297 conditions, which is a 300 percent increase in the amount of conditions listed from the first edition of the DSM, which was created only forty years prior.¹⁷⁸ For example, some scholars cite to the fact that the DSM-V added seventeen new sexual disorders, despite having little scientific evidence for any underlying

specific developmental disorder or learning disability; or an intellectual disability”); *see also* discussion *infra* pp. 34–45.

¹⁷⁶ 29 U.S.C. § 1185a(e)(4) (2012) (“The term ‘mental health benefits’ means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.”).

¹⁷⁷ *See* Churchill, *supra* note 140, at 530.

¹⁷⁸ Douglas A. Hass, *Could the American Psychiatric Association Cause You Headaches? The Dangerous Interaction Between DSM-5 and Employment Law*, 44 LOY. U. CHI. L.J. 683, 690 (2012) (“A comparison of the DSM-IV with the DSM-I demonstrates one reason why: the DSM-IV lists 297 different mental disorders, or approximately 300% more than the DSM-I published just forty-two years earlier.”).

biological condition that could provide a reason for their existence.¹⁷⁹

b. The DSM is Not Realistic

Furthermore, many critics of the DSM posit that simply because a disorder—such as depression—is listed in the DSM, that even if an individual meets all of the diagnostic criteria for the condition, it is not debilitating to the extent that it warrants being a reimbursable medical condition.¹⁸⁰ Such critics, therefore, aver that utilization of the DSM-V is too nebulous and protracted to affirmatively provide legal definitions for mental health disorders.¹⁸¹

c. The DSM is Not Reliable

Lastly, some critics claim that the DSM is generally downright undependable. This was made evident during studies which exhibited that the DSM-IV had much lower kappa values than the previous editions.¹⁸² Cohen's kappa is a unit of measurement which predicts how likely it is that two clinicians will agree on a diagnostic label for patients presenting similar symptoms.¹⁸³ During DSM-IV field trials, however, kappa values used in previous versions of the DSM which may have been seen as “poor” or “unacceptable,” were considered “good” for the DSM-IV.¹⁸⁴ Many critics viewed these new standards as undeniable evidence that the DSM-IV has lost a lot of its reliability, specifically in regard to diagnosing conditions.¹⁸⁵ For example, mixed anxiety-depressive disorder attained a negative kappa, which means that in regard to that condition, clinicians would have been better off simply *guessing* at the diagnosis once they were presented with the symptoms.¹⁸⁶ Given these questions of length and reliability, many have strongly insisted that the DSM should not be used as a source for defining mental health conditions.

¹⁷⁹ *See id.* (internal citations omitted) (“For example, the *DSM-IV* added seventeen new sexual disorders, ‘despite little to no empirical evidence of any underlying disease process that could account for their existence.’”).

¹⁸⁰ *See id.* at 691.

¹⁸¹ *See id.*

¹⁸² *See* RACHEL COOPER, *DIAGNOSING THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 50 (2014).

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *See id.* at 52.

¹⁸⁶ *Id.*

ii. Response: Adding a List of Excluded Conditions to the Legislation Resolves Concerns about the DSM's Length and Reliability

The concerns about using the DSM-V as a definitional source for mental health conditions are all undeniably legitimate. These problems could be resolved, however, by Congress adding a list of conditions that would be exempt from the rule, similar to the mental health parity laws enacted by both Connecticut and Utah. Congress can achieve this by assembling a committee of mental health and medical professionals—just as President Bush did for his Mental Health Commission¹⁸⁷—then have the committee study the DSM vigorously, and arrive at a consensus as to which conditions should not be included in the MHPAEA. By doing so, these professionals would eliminate from coverage the mental health disorders that they determine to be either too trivial or scientifically unproven. Then, what will remain is a DSM that espouses only the mental health conditions that have a wide-ranging consensus as to their “worthiness” of coverage, which Congress can then ratify.

Critically, the DSM has been commonly used in numerous legal contexts—including the Supreme Court of the United States¹⁸⁸—which further substantiates its reliability. Using the DSM as a definitional source for health insurance providers also has previous Congressional support. In 2000, Congress mandated that all health insurance providers that covered government employees under the Federal Employee Health Benefit Programs (FEHB) were mandated to provide parity in coverage, and were additionally required to use the DSM as the source for treatable conditions.¹⁸⁹ Thus, utilizing the most recent edition of the DSM in this manner would only extend to the general

¹⁸⁷ Letter from Michael F. Hogan, Chairman, President's New Freedom Comm'n on Mental Health, to George W. Bush, President of the United States, (July 22, 2003), <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/ExecSummary.pdf> (stating that the commission of medical professionals assembled was mandated to “study the mental health service delivery system, and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities”).

¹⁸⁸ See generally *Atkins v. Virginia*, 536 U.S. 304 (2002) (discussing the constitutionality of imposing the death penalty on those with intellectual disabilities).

¹⁸⁹ *FEHB Program Carrier Letter*, U.S. OFF. OF PERSONNEL MGMT., <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2000/2000-17.pdf> (last visited Jan. 7, 2017) (“You must provide coverage for clinically proven treatment for mental illness and substance abuse. We expect that will include all categories of mental health and substance abuse conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) . . .”).

population what the government currently requires for its own employees.

C. *Proposed Statutory Language for the Revamped MHPAEA*

The statutory language used by Georgia, Connecticut and Utah offers significant advantages over the MHPAEA, in that it does not offer two gaping statutory loopholes, and it truly compels health insurance providers to provide parity in coverage. The following proposed statutory language borrows many themes and concepts utilized by the three aforementioned states, and synthesizes them into a concise, coherent, and intelligible statute. Granted, it is certainly not impeccable by any means, but it would offer significantly greater federal protections to those suffering from mental illnesses, than the current version of the MHPAEA. The following is the proposed statutory language:

Any health plan¹⁹⁰ issued within the United States and its territories, authorized by law to issue insurance plans that cover sickness, accidents, or medical coverage, must provide to its beneficiaries coverage for mental illnesses and disorders.

The coverage for mental illnesses and disorders shall be indistinguishable from that of the coverage for physical illnesses, in every way, and manner.

This shall include *fiscal restrictions*: in no way or manner may the financial obligations of the beneficiary for mental health coverage be more onerous than that for the coverage of physical diseases. This shall include, but is not limited to, co-payments at the time of service, and annual or lifetime dollar limits.

This shall also include *numerical restrictions*: in no way or manner may the insurance provider impose more onerous numerical limits on the beneficiary for mental health benefits, than they would for benefits related to physical diseases. This includes, but is not limited to, the number of inpatient, and outpatient treatment days that a beneficiary may seek under his or her individual plan.

Any benefits that are eligible to be paid by the insurance

¹⁹⁰ The term “health plan” was purposefully chosen in order to have an effect on the widest possible array of health insurance plans, including traditional health insurance plans and self-funded policies. See, for example, 45 C.F.R. § 160.103 (2000) which defines “health plan” to include, *inter alia*, “group health plan[s] . . . health insurance issuer[s] . . . an employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.”

provider on behalf of the beneficiary to a licensed physician, for the physician's services, must also be made available, in regards to the percentage of the services paid for, to the appropriate healthcare professionals, including, but not limited to: licensed psychologists, clinical social workers, and licensed drug and alcohol counselors.

'Mental Illnesses and Disorders' shall be defined as anything listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, released by the American Psychiatric Association (APA). Any updates or conditions subsequently added to the manual by the APA, will automatically extend coverage for those condition(s), until such time that this law will be amended to explicitly exclude it.

'Mental Illnesses and Disorders' does not include the following conditions: caffeine-related disorders; relational disorders; and marital or family-related issues.¹⁹¹

V. CONCLUSION

Overall, despite the MHPAEA's laudable intentions, discrimination against those with mental health and/or substance abuse disorders is still rampant throughout the insurance industry. In fact, in May 2015, seven years after the passage of the MHPAEA and countless state parity laws, more than a dozen senators wrote a letter to the U.S. Department of Health and Human Services demanding that it "increase consumer protections" to those seeking mental health and/or substance abuse treatments.¹⁹² The senators felt compelled to

¹⁹¹ Another essential area which requires parity in coverage is in regard to determining what constitutes a "medical necessity review." If, for example, a doctor tells his patient to go to physical therapy for two weeks, and the health insurance provider covers this treatment, yet refuses to cover a patient who seeks intensive therapy for two weeks as per the recommendation of a psychiatrist, stating that it is not "medically necessary," it is essential that the rubric utilized to make that determination not be disparate in regard to mental health conditions and physical illnesses. The statutory language proposed does not address this aspect of parity, because, although the medical necessity issues and parity generally mesh in many regards, they are two distinct problems, and this Comment does not intend to focus on the medical necessity issue. See discussion *supra* p. 14.

¹⁹² The letter states, in relevant part, that:

We are writing to ask that you increase consumer protections for patients seeking coverage for mental health and substance use services and treatments. . . . it has come to our attention that many Americans still have health plans that create additional barriers to accessing mental health and substance use disorder services

Letter from Richard Blumenthal et al., U.S. Sen., to Sylvia Mathews Burwell, Sec'y, U.S. Dep't of Health and Human Servs. (May 8, 2015), <http://www.help.senate.gov/ranking/newsroom/press/senators-blumenthal-murray-franken-and-colleagues-urge->

write the letter since many of their constituents still faced “additional barriers” to accessing the care that they needed, and because insurance companies were not providing their beneficiaries with sufficient in-network treatments for mental health and substance abuse disorders.¹⁹³

It is incontestable that the MHPAEA needs to be amended. It is further indisputable that bold reforms are required in order to usher in an era that boasts true parity in healthcare coverage, and modifying the MHPAEA and subsequently amending the ACA to include those modifications would make great strides in this regard. While the suggested amendments and revised statutory language of the MHPAEA may not be impeccable, they, if enacted, would expunge many of the loopholes present in the current legislation and usher in a new age in which mental health conditions are not viewed as inferior, and therefore subject to discrimination. Rather, the amendments and proposed statutory language recommended in this Comment will finally compel health insurance providers to eradicate any lingering discrimination, or vestiges thereof, and provide help to those who seek it.

hhs-to-ensure-coverage-for-critical-mental-health-care.

¹⁹³ *Id.*