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Mental Health Parity Laws and Suicidality: Coverage, Cost, and the Catch-22 of Having to Prove That a Disparity Exists, to Prove That a Disparity Exists

Sylvia Lee

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Mental Health Parity Laws and Suicidality: Coverage, Cost, and the Catch-22 of Having to Prove That a Disparity Exists, to Prove That a Disparity Exists

Introduction: The Problem of Suicide

Suicide is among the top ten causes of death in the United States. The CDC reported 45,979 deaths by suicide in 2020, or one death every 11 minutes. An estimated 12.2 million American adults seriously contemplated suicide, 3.2 million planned a suicide attempt, and 1.2 million attempted suicide.[1]

Suicide is also strongly correlated with mental illness. Researchers believe that nearly all individuals who commit suicide have a diagnosable mental illness. Two-thirds of people who commit suicide are estimated to have a depressive illness, 5% are estimated to have schizophrenia, and 10% are believed to meet the criteria for other mental illnesses, including borderline personality disorder.[2] Yet, only half of the people who die by suicide receive mental health treatment in their lifetimes.[3] Only about one-third of people who die by suicide had contact with a mental health service provider within the year of their death, and only one in five

[1] Facts about suicide, Centers for Disease Control and Prevention (2022), https://www.cdc.gov/suicide/facts/index.html (last visited Apr 20, 2022).
[2] Jonathan Klick & Sara Markowitz, *Are Mental Health Insurance mandates effective? evidence from suicides*, 15 Health Economics , 83-97 (2005).
[3] *Id*.

people who die by suicide had contact with a mental health service provider within the month of their death.[4]

This paper explores the effect of mental health parity laws on the problem of suicide. Part 1 establishes the link between health insurance and suicidality. Part 2 traces the legislative history of mental health parity laws and introduces the hurdles involved with mental health care lawsuits. Part 3 addresses the struggle that courts go through as they navigate these hurdles. Specifically, it underlines the courts' struggle to define non-quantitative treatment limitations in mental health care coverage and the lack of a pleading standard in case law. Finally, Part 4 explains why mental health care coverage matters and proposes a case for a coverage mandate and additional transparency in mental health care coverage.

Part 1: Health Insurance and Suicidality

Suicide and Mental Health Care

State-level suicide rates are strongly correlated with general mental health measures, such as depression and self-reported poor mental health episodes. Approximately 90% of suicides come from individuals with a mental illness.[5] In particular, the suicide rate for those with major depression can be as high as 17.7%.[6]

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[4] Jason B. Luoma et al., *Contact with mental health and Primary Care Providers before suicide: A review of the evidence*, 159 American Journal of Psychiatry , 909-916 (2002).
[5] Matthew Lang, *The impact of mental health insurance laws on state suicide rates*, 22 Health Economics , 73-88 (2011).
[6] *Id*.

Suicide prevention typically focuses on treating an individual's underlying mental health illness in the hope that treatment in and of itself will reduce suicidal thoughts. Research suggests that treatment should directly target and treat suicidal thoughts and behaviors using evidence-based interventions.[7] For example, research has demonstrated that therapy is effective in treating conditions such as depression and anxiety and can be adapted for suicide prevention.[8] Controlled trials have shown that cognitive behavioral therapy, dialectical behavioral therapy, and collaborative assessment and management of suicidality are effective in reducing suicidal thoughts and behaviors.[9] In turn, studies of collaborative assessment and management of suicidality have shown reductions in suicidal ideation, depression, hopelessness, and visits to primary care and emergency departments.[10] The evidence shows that mental health care is an effective means to reduce suicide rates.

On the other hand, health insurance mandates are an effective way to improve health outcomes. If mental health parity laws are to directly cause a decrease in suicide rates, then the parity laws must increase mental health care utilization. Increased mental health care utilization leads some individuals to treat their mental illnesses and eventually prevents them from committing suicide.[11] Suicide rates are strongly correlated with overall mental health. This relationship between mental illness and suicide suggests that policies that are intended to reduce the suicide rate may also improve overall mental health, and vice versa.

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[7] Michael F. Hogan & Julie Goldstein Grumet, *Suicide prevention: An emerging priority for health care*, 35 Health Affairs 1084–1090 (2016).
[8] *Id*.
[9] *Id*.
[10] *Id*.
[11] Lang, *supra*, note 5.

The Coverage and Cost Barriers to Mental Health Care Access

Only about half of people who die by suicide receive mental health treatment in their lifetimes.[12] The lack of mental health care access is not limited only to people who commit suicide. Three-fifths of adults with a recent onset of mental health illness do not receive care from either a general medical provider or a mental health specialist.[13] Not everyone needs treatment. However, even individuals with serious mental health illnesses often do not seek the treatment they need.

There are many barriers that prevent individuals with mental health illnesses from seeking care, such as stigma, negative attitudes toward treatment, differing interpretations of mental health symptoms, and the availability of mental health care providers. However, it should be noted that the National Comorbidity Study found that 47% of respondents with a mental illness who said that they thought they needed mental health care cited costs or not having health insurance as a reason why they did not seek mental health care.[14] Similarly, a survey by the National Alliance on Mental Illness found that nearly twice as many respondents had been denied coverage for mental health care than for physical health care.[15] Yet, patients have sought

[12] Klick, *supra*, note 2.
[13] Kathleen Rowan et al., *Access and cost barriers to mental health care, by insurance status*, 1999–2010, 32 Health Affairs , 1723-1730 (2013).
[14] Philip S. Wang et al., *Twelve-month use of mental health services in the United States*, 62 Archives of General Psychiatry 629 (2005).
[15] A long road ahead, NAMI, https://nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead (last visited Apr 26, 2022) (describing a survey conducted by the National Alliance on Mental Illness assessing the experiences of people living with mental illness and their families with private health insurance).

mental health care treatment out-of-network almost three to six times more often than they sought physical health care out-of-network.[16]

People with mental illnesses are less likely to have health insurance than those without mental illnesses. In general, there is a decline in private insurance and an increase in public insurance for people with mental illnesses.[17] Additionally, people with serious mental illnesses are less likely than people with moderate or no mental illnesses to have private health insurance and more likely to have public insurance. Public insurance is the most common form of coverage for those with the types of serious mental illnesses that correlate most to suicide.

Cost is also a very significant barrier that can impede mental health care access even among the insured population. People with mental illnesses tend to have lower family incomes and are more likely to be living in poverty.[18] There is a continuing movement toward increased cost sharing for people with health insurance. Yet, cost sharing may disproportionately affect people with mental illnesses, especially those who have serious mental illnesses. People with mental illnesses have substantial out-of-pocket costs for their care. 14% of working age persons with mental illness have out-of-pocket expenditures that exceed 20% of their annual family income.[19] Those who cannot afford their out-of-pocket costs may choose to forgo treatment,

[16] Senator Warren, rep. Kennedy Reintroduce Behavioral health coverage transparency act, legislation to prevent discrimination against patients seeking mental health and addiction care (2019), https://www.warren.senate.gov/newsroom/press-releases/senator-warren-rep-kennedy-reintroduce-behavioral-health-coverage-transparency-act-legislation-to-prevent-discrimination-against-patients-seeking-mental-health-and-addiction-care (last visited Apr 26, 2022).
[17] Rowan, *supra*, note 13.
[18] Rowan, *supra*, note 13.
[19] Rowan, *supra*, note 13.

which then leads to poor management of their mental illness and can further lead to higher suicide rates.

Part 2: The Legislative History of Mental Health Parity Laws

The Early Days: State Laws and the MHPA

Health insurance plans have historically offered less generous coverage for mental health care services compared with that for physical health care services.[20] A few states began enacting mental health insurance mandates as early as in the 1970s and 1980s, but the nationwide push for mandates, and for mental health parity mandates in particular, began in earnest in the early 1990s.[21]

The Federal Mental Health Parity Act (MHPA) was passed in Congress and signed into law in 1996. The MHPA offered partial parity to 'level the playing field' between mental and physical health care coverage.[22] It also prohibited group health plans that already offered mental health care coverage from imposing annual and lifetime limits that were greater than the limits imposed on physical health care coverage.[23] In other words, if a health insurance plan included

[20] Katherine M. Harris et al., *The effects of state parity laws on the use of Mental Health Care*, 44 Medical Care, 499-505 (2006).
[21] Klick, *supra*, note 2.
[22] Lang, *supra*, note 5.
[23] Michael C. Barnes, Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment 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 (2014).

physical health benefits, then the annual and lifetime limits of mental health care offered by the plan must be the same as the plan's physical health benefits. The MHPA was limited in scope. The law did not require health insurance plans to cover mental health care. There were no restrictions on the terms and conditions covered in mental health plans if they were offered. Finally, employers with 50 or fewer employees were exempt from the MHPA.[24] The MHPA expired in 2007.

Eleven states had some type of mental health insurance law enacted prior to the MHPA.[25] More states enacted their own parity laws after the MHPA. Some 45 states had mental health legislation by 2002. The MHPA did not necessarily cause states to pass mental health legislation, but there was correlation, and some managed behavioral healthcare companies argued that the federal act 'legitimize[d] advocates at the state level.'[26] The scope of state laws varied greatly. Some required full parity, where insurers must provide mental health benefits at exactly the same terms that they applied to physical health benefits, whereas others set a maximum number of provider visits and did nothing to limit patients' cost sharing.[27] Furthermore, some states defined mental illness broadly and applied their mandate to virtually any mental illness listed in the DSM, whereas others limited coverage to more "biologically based" illnesses like schizophrenia, bipolar disorder, and major depressive disorders.[28] The suicide rate was 5% lower in states where full parity laws were enacted, while the suicide rate increased by 2% when a state enacted a mandate that did not require mental health care to be affordable relative to physical health care.[29]

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[24] *Id*.
[25] Lang, *supra*, note 5.
[26] Lang, *supra*, note 5.
[27] Lang, *supra*, note 5.
[28] Klick, *supra*, note 2.
[29] Lang, *supra*, note 5.

The MHPAEA

The more comprehensive Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law in 2008. The MHPAEA strengthened the MHPA and filled in some of its gaps. The MHPAEA is a "mandate if offered" law that requires group health care plans of over 50 employees to include mental health benefits, if they are offered, at the same level as physical health benefits. More specifically, the MHPAEA requires health plans to: (1) identify treatment limitations and financial requirements that are imposed on mental health benefits, (2) compare those specific standards to coverage that applies to physical health benefits, and (3) modify any standard that is "separate from or more restrictive than" those imposed on physical health benefits.[30]

Mental health benefits and physical health benefits are equalized under the MHPAEA in four fundamental ways. First, the MHPAEA specifically prohibits group health plans from imposing separate or more restrictive financial requirements or treatment limitations on mental health benefits.[31] Second, the MHPAEA prohibits health plans from denying insurance reimbursement when beneficiaries reach a lifetime or annual spending cap imposed solely on mental health care.[32] The MHPAEA does not require health plans to offer mental health benefits, but plans that do offer mental health benefits are subject to the MHPAEA. Third, the MHPAEA's parity regulations impose non-discrimination standards on medical management

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[30] 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, 208 (2013).
[31] *Id*. at 183.
[32] *Id*.

practices, medical necessity determinations, and provider network and compensation practices.[33] These standards are the barriers that are typically cited when limiting mental health care coverage and raising costs. Lastly, The MHPAEA offers a remedy for health insurance discrimination that was not provided under the Americans with Disabilities Act.[34]

The Affordable Care Act (ACA), signed into law in 2010, significantly expanded the existing protections under the MHPAEA. As of 2014, individual and small group plans must also comply with mental health care parity under the ACA's Essential Health Benefits package.[35] Wrongful denials of mental health care coverage violate the MHPAEA when limitations are not applied at parity with physical health care coverage. When this happens, the plan violates the ACA as well. In other words, MHPAEA violation claims are no longer limited to large group plans; thus, more individuals can seek enforcement of parity laws. However, two limitations on the MHPAEA's reach still remain. First, employer-based insurance plans retain the right to not provide any mental health benefits at all and may define the conditions and services that they would offer for mental health illnesses, limited only by the MHPAEA's standards and by any applicable state law.[36] Second, health plans retain the right to make medical management decisions that could limit or deny care.[37]

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[33] *Id*. at 183-84.
[34] *Id*. at 184.
[35] Barnes, *supra*, note 23.
[36] Weber, *supra*, note 30 at 204.
[37] Weber, *supra*, note 30 at 206.

QTLs and NQTLs

The MHPAEA requires parity in all plan features, such as cost sharing, durational limits, and plan management practices. This includes both quantitative treatment limitations (QTLs), which can be expressed numerically, such as the limits on the number of covered visits to a provider, and non-quantitative treatment limitations (NQTLs), which are not expressed numerically, but can otherwise "limit the scope or duration of benefits for treatment under a plan."[38] NQTLs include medical management standards, such as medical necessity or appropriateness standards, experimental or investigative treatment standards, preauthorization requirements, prescription drug formulary standards, standards for admission to provider networks, reimbursement rates, or a plan's method of determining usual, customary, and reasonable charges.[39]

Health insurance plans generally deny access to mental health coverage under both categories. QTLs are evaluated based on numerical values and are therefore easier to enforce. State insurance departments use plan cost data to determine QTL standards and verify that the same numerical value is applied to both mental and physical health care when ensuring that their states are in compliance with the MHPAEA.[40] Thus, QTL challenges are hardly ever brought to court.

NQTLs, on the other hand, are much more difficult to evaluate and enforce. The MHPAEA provides that the "processes, strategies, evidentiary standards, or other factors" used in applying the NQTL to mental health care benefits "[must be] comparable to, and . . . applied

[38] 29 C.F.R. § 2590.712
[39] Weber, *supra*, note 30.
[40] Weber, *supra*, note 30 at 255.

no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to [physical health care benefits]."[41] However, variations are allowed in NQTL standards if "recognized clinically appropriate standards of care . . . permit a difference"[42] These variations lead to NQTLs being imposed differently between specific health benefits across both mental and physical health benefits. The test for comparing NQTLs for mental health care to physical health care looks to whether the mental health care standard in question is "comparable to" or "applied more stringently than" a physical health care standard.[43] To evaluate an NQTL challenge, a plan must be willing to analyze all information related to physical health benefit standards with comparable management standards to mental health benefit standards as well as the "processes, strategies, or evidentiary standards" that have been used to develop those standards.[44] Unfortunately, there is no regulatory definition that clearly underlines what makes a mental health benefit "comparable" to a physical health benefit. Sometimes, no comparison can be made because a mental health service might not have an analogue in physical health care. Moreover, many benefits, across both mental and physical health care, are condition-specific, which can also make them impossible to compare. The vast majority of MHPAEA challenges brought to court are NQTL challenges.

Litigation

MHPAEA challenges brought under a contract theory, the claim that benefits were denied arbitrarily and capriciously, tend to fail because of a Rule 12(b)(6) failure to state a claim.

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[41] 26 C.F.R. § 54.9812-1T(c)(4)(i); 29 C.F.R.§ 2590.712(c)(4)(i); 45 C.F.R. § 146.136(c)(4)(i)
[42] *Id*.
[43] Weber, *supra*, note 30 at 219.
[44] Weber, *supra*, note 30 at 220.

Courts have ruled that it is insufficient to state a claim if the plaintiff alleges that the defendant insurance company did not apply the same NQTL standards to a mental health benefit as a physical health benefit but does not "apply the acute standard to the subacute [physical health care] analogues."[45] These comparisons are difficult to make prior to discovery.

Instead, most MHPAEA challenges are brought under the Employee Retirement Income Security Act (ERISA). Individuals with employee benefit plans may bring suit under ERISA to challenge a denial of benefits that violates the ACA or the MHPAEA, and "[a]lmost all health benefits plans offered through private employers are governed by ERISA." [46] ERISA preempts state law. Under ERISA § 502(a), plan participants and beneficiaries can challenge MHPAEA violations by bringing a case "to recover benefits due to [them] under the terms of [their] plan[s], to enforce [their] rights under the terms of the plan[s], or to clarify [their] rights to future benefits under the terms of the plan[s]."[47] ERISA "limits the remedies for violations of [the MHPAEA] to equitable relief: the provision of the benefit allowed under the plan or reimbursement for cost of care."[48] However, by bringing an ERISA claim, an individual can challenge a plan for "any act or practice" that violates ERISA provisions, which includes the MHPAEA. This allows a plan beneficiary to challenge a wide range of violations, such as restrictive financial requirements, QTLs, and NQTLs.

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[45] *Patrick S. v. United Behav. Health*, No. 2:20-CV-283-TS, 2021 WL 308221 (D. Utah Jan. 29, 2021) (holding that a defendant insurance company's application of an acute medical necessity criteria to the subacute inpatient mental health treatment without applying the acute standard to the subacute inpatient medical/surgical analogues is sufficient to state a claim).
[46] Barnes, *supra*, note 23 at 593.
[47] 29 U.S.C. § 1132(a)(1)(B); Weber, *supra*, note 30 at 225-26.
[48] Weber, *supra*, note 30 at 226.

Part 3: The Problems With Enforcing the MHPAEA

The NQTL Problem

The Employee Benefits Security Administration (EBSA) enforces ERISA, and the Centers for Medicare & Medicaid Services (CMS) enforces the MHPAEA. EBSA and CMS investigate MHPAEA violations in the following categories: (1) annual dollar limits, (2) aggregate lifetime dollar limits, (3) financial requirements, (4) treatment limitations, (5) cumulative financial requirements and QTLs, and (6) benefits in all classifications.[49] QTLs, which make up the first five of the six categories listed above, are clearly defined. NQTLs, on the other hand, are essentially lumped into one catch-all category.

Case law in this area tends to be fact-specific to the exact details of the plan that is called into question. There is no comprehensive set of rules that defines the scope of mental health care. Generally, however, health plans that restrict the continuum of services for mental health care while providing a full spectrum of services to treat physical conditions are found in violation of the MHPAEA.[50] Case law also tends to focus on non-quantitative disparities between access to mental health care and physical health care, which are less obvious than their quantitative counterparts. There is only one catch-all category for the enforcement of NQTLs, yet the majority of court cases are centered around this one vaguely defined category. This has forced courts to enforce NQTLs on a case-by-case basis for treatment limitations such as the denial of medical necessity, the exclusion of certain benefits, and the categorical exclusion of a specific

[49] EBSA, Employee Benefits Security Administration, https://www.dol.gov/agencies/ebsa (last visited Apr 9, 2022).
[50] Weber, *supra*, note 30.

program.[51] Courts struggle with enforcing the MHPAEA because NQTLs, which make up the majority of challenges, are so broadly defined. Not only do courts have to determine what subcategory of NQTLs any particular case falls under without much guidance from EBSA or CMS, forcing them to depend heavily on the facts surrounding the specific plan in question and how the plan compares the mental health benefits it offers to the physical health benefits it offers, but courts more often than not have to make this determination at the pleading stage, prior to discovery where the relevant facts can be found.

The Pleading Problem

"There is no clear law on how to state a claim for a [MHPAEA] violation," so "district courts have continued to apply their own pleading standards."[52] Plaintiffs can state a claim under the MHPAEA using any pleading standard. There are only a handful of binding opinions from higher federal courts, namely from the Second and Ninth Circuits. However, neither circuit court has been helpful in clarifying the law outside of a very specific set of circumstances. The Second Circuit cases generally hold that psychiatric providers cannot bring suit alleging ERISA claims and violation of the MHPAEA on behalf of their patients.[53] Meanwhile, the Ninth Circuit has consistently held that mental or behavioral health coverage must be provided at the same level as

[51] *See Patrick S. v. United Behav. Health*, No. 2:20-CV-283-TS, 2021 WL 308221 (D. Utah Jan. 29, 2021) (medical necessity); *see also Munnelly v. Fordham Univ. Fac.*, 316 F. Supp. 3d 714 (S.D.N.Y. 2018) (exclusion of certain mental health benefits*); see also Gallagher v. Empire HealthChoice Assurance, Inc.*, 339 F. Supp. 3d 248 (S.D.N.Y. 2018) (categorical exclusion of a specific mental health program).
[52] *Michael W. v. United Behav. Health*, 420 F. Supp. 3d 1207, 1234 (D. Utah 2019).
[53] *See Am. Psychiatric Ass'n v. Anthem Health Plans, Inc.*, 821 F.3d 352 (2d Cir. 2016); *see also New York State Psychiatric Ass'n, Inc. v. UnitedHealth Grp.*, 798 F.3d 125(2d Cir. 2015).

physical health coverage under parity laws even when the plan itself does not contractually require it.[54] However, the Ninth Circuit has done little to define the scope of the MHPAEA.

MHPAEA cases typically hinge on summary judgment motions or motions to dismiss — the plan in question either complies with parity requirements under the MHPAEA, or it does not. One popular pleading standard among defendant insurance companies is the *Welp* pleading standard. The *Welp* standard requires plaintiffs to:

> (1) identify a specific treatment limitation in [the] plan applicable to behavioral health treatment; (2) identify services in the [physical health care] arena that are both covered under the plan and analogous to the specific [mental health care] services at issue; and (3) plausibly allege a disparity in the limitation criteria applicable to this analogous [physical health care] service on the one hand and the mental health or substance use treatment on the other.[55]

It is the third prong of the *Welp* standard where plaintiffs tend to struggle. The *Welp* standard requires plaintiff to show 'something' that plausibly points to an insurance company's disparate treatment of mental health care benefits and physical health care benefits. Unfortunately, this is difficult to allege without discovery, as it would require plaintiffs to have information about plan details that they may not have access to until discovery.

Some courts have either adopted the *Welp* standard or created similar standards based off it.[56] Many courts, on the other hand, have found the *Welp* standard unpersuasive because it is too

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[54] *See Danny P. v. Cath. Health Initiatives*, 891 F.3d 1155(9th Cir. 2018); *see also Stone v. UnitedHealthcare Ins. Co.*, 979 F.3d 770 (9th Cir. 2020); *see also Harlick v. Blue Shield of California*, 686 F.3d 699 (9th Cir. 2012).
[55] *Patrick S. v. United Behav. Health*, No. 2:20-CV-283-TS, 2021 WL 308221 (D. Utah Jan. 29, 2021) (citing *Welp v. Cigna Health & Life Ins. Co.*, No. 17-80237-CIV, 2017 WL 3263138 (S.D. Fla. July 20, 2017)).
[56] *Id*.

strict.[57] Instead, those courts have held that plaintiffs may "allege that the plan *as applied* by the insurance administrator violates the [MHPAEA]" even if they "do not plead a plausible *facial* [MHPAEA] challenge to an insurance plan on its own terms."[58] Courts in the Seventh Circuit have generally expressed similar concerns about a plaintiff's ability to obtain specific information during the pleading stage prior to discovery.[59] For example, the Northern District of Illinois district court in 2016 found that the plaintiffs had successfully pled a cause of action under the MHPAEA and rejected the defendant's argument that the plaintiffs failed to allege "treatment limitations on medical/surgical benefits which, when compared to mental health benefits, demonstrate disparity."[60] In particular, the Illinois court observed that at the pleading stage, plaintiffs are "unlikely to be aware of the potential range of 'recognized clinically appropriate standards of care' which may give rise to a difference in how mental health and medical services are treated and thus they would be left to speculate as to the clinical reasons for a particular disparity."[61] Later that year, the Illinois court also concluded that a plaintiff's complaint "adequately alleges" a defendant insurance company's failure to apply comparable standards to mental health benefits as the plan's physical health benefits by failing to cover residential treatment centers for mental illnesses.[62] Here, the court noted that "[d]iscovery will reveal what sort of process, strategy, evidentiary standard, or other factors [the defendant] used

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[57] *See Michael W. v. United Behav. Health*, 420 F. Supp. 3d 1207 (D. Utah 2019); *see also Smith v. Golden Rule Ins. Co.*, 526 F. Supp. 3d 374 (S.D. Ind. 2021).
[58] *Michael W. v. United Behav. Health*, 420 F. Supp. 3d 1207, 1235 (D. Utah 2019) (emphasis in original).
[59] *Smith v. Golden Rule Ins. Co.*, 526 F. Supp. 3d 374, 388 (S.D. Ind. 2021).
[60] *Craft v. Health Care Serv. Corp.*, 2016 WL 1270433, at 11 (N.D. Ill. Mar. 31, 2016).
[61] *Id*. (citing *C.M. v. Fletcher Allen Health Care, Inc.*, 2013 WL 4453754, at 6 (D. Vt. April 30, 2013)).
[62] *Natalie V. v. Health Care Serv. Corp.*, 2016 WL 4765709, at 8 (N.D. Ill. Sept. 13, 2016) (denying defendant insurance company's motion to dismiss for failure to state a claim).

in setting its treatment limitations, including its blanket ban on residential treatment centers for mental illness."[63] The nature of MHPAEA claims is that they generally require further discovery to evaluate whether there is in fact a disparity between the availability of treatments for mental health illnesses and treatment for physical health conditions. A plaintiff should only need to plead as much of a prima facie case as possible based on the information in their possession at the time.

The ultimate issue in any MHPAEA case is whether the plaintiff has plausibly alleged that their health insurance plan applied a disparate or more restrictive treatment limitation to mental health care versus physical health care. The different pleading standards provide a framework for considering that question as it relates to different types of MHPAEA violations. Interestingly, even courts that have rejected the *Welp* standard for being too strict still appear to have required plaintiffs to show 'something' that would meet the *Welp* standard's third prong of "plausibly alleg[ing] a disparity in the limitation criteria applicable to [an] analogous [physical health care] service on the one hand and the [mental health care] treatment on the other."[64]

For example, in *Patrick S. v. United Behav. Health*, the court denied the defendant insurance company's motion to dismiss because the plaintiff successfully alleged that the plan applied a more stringent medical necessity criteria to the patient's mental health impatient treatment than the medical necessity criteria for physical health impatient treatment.[65] In *Munnelly v. Fordham Univ. Fac.*, the court found that the insurance plan's provision excluding

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[63] *Id*.
[64] *Welp v. Cigna Health & Life Ins. Co.*, No. 17-80237-CIV, 2017 WL 3263138 (S.D. Fla. July 20, 2017).
[65] *Patrick S. v. United Behav. Health*, No. 2:20-CV-283-TS, 2021 WL 308221 (D. Utah Jan. 29, 2021).

coverage of mental health benefits for residential treatment violated the MHPAEA because residential treatment was available for physical health care.[66] Similarly, in *Gallagher v. Empire HealthChoice Assurance, Inc.*, the plaintiff successfully alleged that the insurance plan had a lack of parity because it covered "intermediate medical/surgical treatment in an outdoor 'wilderness' setting" but did not cover mental health care in the same setting.[67] Finally, in *Smith v. Golden Rule Ins. Co.*, plaintiffs successfully alleged that the insurance plan preemptively authorized for diagnostic tests, such as urine analysis tests, for diabetes but did not preemptively authorize urine analysis tests for mental health and substance use disorders.[68]

In summary, courts have more or less allowed plaintiffs to survive a summary judgment motion to dismiss so long as they were able to allege *any* disparity between how a plan treated mental health care coverage and physical health care coverage.[69] By so doing, courts have in effect applied the MHPAEA to the specific facts of each individual case to find the 'something' that, in theory, would allow plaintiffs to meet the *Welp* standard. Other than to uphold the language of the MHPAEA itself, there is no comprehensive interpretation as to the scope of what counts as a disparity or not. While this keeps the opportunity open for plaintiffs who want to allege that their mental health care benefits were not treated at parity with their physical health care benefits, it also allows insurance plans continue to discriminate against mental health care

[66] *Munnelly v. Fordham Univ. Fac.*, 316 F. Supp. 3d 714 (S.D.N.Y. 2018).
[67] *Gallagher v. Empire HealthChoice Assurance, Inc.*, 339 F. Supp. 3d 248, 256 (S.D.N.Y. 2018).
[68] *Smith v. Golden Rule Ins. Co.*, 526 F. Supp. 3d 374 (S.D. Ind. 2021).
[69] *but see Wit v. United Behav. Health*, No. 20-17363, 2022 WL 850647 (9th Cir. Mar. 22, 2022) (reversing the district court's finding for the plaintiff plan beneficiaries that the insurance companies actions resulted in uncertainty concerning the scope of their benefits and the material risk of harm to their contractual rights, and holding that mental health care plans do not require consistency with generally accepted standards of care so long as coverage is not 'inconsistent' with generally accepted standards of care).

coverage with respect to NQTLs so long as there is no comprehensive framework in place to clearly indicate at which point a plan begins to discriminate against mental health care coverage.

The courts should work toward identifying one clear pleading standard to apply to all MHPAEA cases. Courts should also reject the *Welp* standard both for being too strict and too vague. The *Welp* standard's third prong requires plaintiffs to "plausibly allege" a discrimination between how an insurance plan treats mental health care coverage and physical health care coverage. However, it does not define at what point exactly a plaintiff has "plausibly alleged" a disparity. Furthermore, it is possible that it was the insurance company's administration of a plan that discriminated against mental health care coverage, not the plan in and of itself. Plaintiffs may not have the means of demonstrating NQTL disparities like this until discovery. Thus, the *Welp* standard could potentially bar plaintiffs from making this claim. Plaintiffs should only need to successfully plead a prima facie case at the pleading stage. They should not be expected to have all the relevant facts at this point of the litigation process.

Part 4: Policy Recommendations

Why Coverage Matters

The suicide rate for those with major depression can be as high as 17.7%, and approximately 90% of individuals who commit suicide had a mental illness.[70] A key belief of the National Strategy for Suicide Prevention is that "suicide deaths for individuals receiving care

[70] Lang, *supra*, note 5.

within [physical health care] and [mental health care] systems are preventable."[71] Thus, health care law should focus on increasing access to mental health care services so people with mental illnesses can obtain the care they need.

The law can begin increasing coverage by eliminating existing legal barriers. For example, providers are better positioned to bring suit on behalf of their patients than the patients themselves, who are in that situation because they have a mental illness and could likely do without the additional anxiety and stress that bringing a lawsuit would create. The Second Circuit should be overruled so that psychiatric providers are able to bring suit alleging ERISA claims and violation of the MHPAEA on behalf of their patients. Next, applicable government agencies should create a consistent definition as to what constitutes mental health care and ensure that insurance companies comply with that definition. This would involve creating standardized analogues between mental health care and physical health care that insurance plans must follow, which would help courts enforce NQTL parity. Insurance companies typically deny mental health care coverage through QTLs and NQTLs. Most case law focuses on NQTLs, which are more difficult to standardize. However, that does not mean that QTLs should be neglected. Ensuring that insurance companies follow the same QTLs could also increase access by decreasing patient confusion as they navigate the mental health care space. This standardization should be implemented at the federal level, much like the MHPAEA itself, to keep standards uniform and easy to navigate.

[71] Christa D. Labouliere et al., *"Zero Suicide" – A model for reducing suicide in United States behavioral healthcare*, 23 Suicidologi (2018).

The Case for a Coverage Mandate

Coverage and cost still remain as barriers to mental health care even after the ACA's expansions. Some provisions of the MHPAEA can help reduce out-of-pocket costs. However, the MHPAEA is a "mandate if offered" law, so its protections do nothing if the insurer chooses not to offer mental health benefits. The MHPAEA only applies if the insurer chooses to provide mental health coverage to begin with. Moreover, the small employers with fewer than 50 employees are exempted from the MHPAEA.

The ACA expanded coverage for previously uninsured individuals with mental health illnesses. It expanded MHPAEA's parity provisions to new plans and defined mental health services as an essential health benefit. The ACA also expanded federal parity provisions to Medicaid Alternative Benefit Plans and plans offered through the individual market. However, self-insured plans are not included in the ACA's coverage mandate for mental health services. Small employers with fewer than 50 employees are still exempt from MHPAEA. Furthermore, having mental health care coverage does not necessarily equate to being able to afford mental health care services. For example, prescription drugs for mental illnesses account for nearly two-thirds of out-of-pocket spending for mental health care, and merely expanding coverage would not reduce this potential barrier to treatment.[72]

A federal coverage mandate should also ensure that all insurance providers who offer mental health care coverage cover a minimum number of therapy sessions for mental health care, helping ensure that patients have access to at least the minimum number of sessions they need until their treatment takes effect. On average, it takes 15 to 20 therapy sessions for 50% of

[72] Rowan, *supra*, note 13.

patients to recover from mental illness, as indicated by self-reported symptom measures.[73] There is little point in giving individuals access to mental health treatment if they will not be given enough treatment to actually treat their illnesses. Some specific psychological treatments can require 12 to 16 weekly sessions before patients show clinically significant improvements.[74] Clinical research evidence even suggests that patients with co-occurring conditions or certain personality difficulties may require longer treatment, such as 12-18 months of consistent treatment, for therapy to be effective.[75]

Health care mandates have historically proven to work. They are an effective way to improve health outcomes. Fertility mandates that mandated care for fertility on the birth rates of women over 35 have significantly increased first birth rates of women over 35.[76] States that mandated substance abuse care as a part of health insurance coverage have experienced an increase in total treatment admissions.[77] Accordingly, implementing a mental health care coverage mandate could improve mental health outcomes, which could in turn help reduce the suicide rate.

The Behavioral Health Coverage Transparency Act

Not only should insurance plans consistently offer the same coverage and costs for mental health care as physical health care but also the same amount of transparency about what

[73] American Psychological Association, http://www.apa.org/ptsd-guideline (last visited Mar 19, 2022).
[74] *Id*.
[75] *Id*.
[76] Lang, *supra*, note 5.
[77] Lang, *supra*, note 5.

their mental health care plan covers. Senator Elizabeth Warren introduced the Behavioral Health Coverage Transparency Act to Congress (BHCTA) in 2019. Though the bill was not signed, it would have:

> "require[d] the Departments of Health and Human Services (HHS), Labor, and the Treasury to (1) cooperatively issue regulations to require group health plans and health insurance issuers to annually disclose the analyses performed to ensure compliance with mental health parity laws, and (2) conduct annual random audits of group health plans and health insurance issuers to determine compliance."[78]

Additionally, the bill would have also required HHS to "establish a consumer parity unit: (1) to facilitate the collection of, monitoring of, and response to consumer complaints; and (2) to provide consumers information about the disclosure requirements and enforcement of the mental health parity laws."[79] The BHCTA has received the support of many advocacy and expert organizations, such as the American Psychological Association, the Association for Behavioral Healthcare, the National Alliance on Mental Illness, the National Safety Council, The Kennedy Forum, and the Massachusetts Medical Society.[80]

If signed into law, the BHCTA could help increase health insurance plans' compliance with mental health parity laws and increase plan transparency. This would alleviate the burden on MHPAEA plaintiffs of having to show detailed knowledge of defendant insurance companies' health plans in order to successfully plead a case before discovery. It would also aid

[78] Behavioral Health Coverage Transparency Act, S. 1576, 116th Cong. (2019).
[79] *Id*.
[80] Senator Warren, rep. Kennedy Reintroduce Behavioral health coverage transparency act, legislation to prevent discrimination against patients seeking mental health and addiction care (2019), https://www.warren.senate.gov/newsroom/press-releases/senator-warren-rep-kennedy-reintroduce-behavioral-health-coverage-transparency-act-legislation-to-prevent-discrimination-against-patients-seeking-mental-health-and-addiction-care (last visited Apr 26, 2022).

plaintiffs in meeting the *Welp* standard in jurisdictions that use it. Most insurance plans are transparent about what aspects of physical health care a plans covers, such as whether dental care or vision care is included in the plan. Information regarding a health plan's mental health care benefits should be as readily available to plan beneficiaries as are the plan's physical health care benefits. There should also be parity in plan transparency as well as plan administration. The same QTL and NQTL standards should apply to both mental and physical health care, even if it can sometimes be difficult to find truly analogues between them. Finally, the disclosure requirements of the BHCTA and the increase in transparency it could provide would not only provide plan beneficiaries with a clearer picture regarding what exactly their insurance plan covers in terms of mental health care, but it could also increase the public's confidence in the entire system overall.

Conclusion

Suicide is strongly correlated with mental illness, and an increase in mental health care access can in turn lead to a decrease in suicide rates. One way in which mental health care access and utilization can be increased are through mental health parity laws. Mental health parity laws are relatively new in the United States. There are only a few cases that have made their way to higher federal courts, and most cases turn upon whether a plaintiff's claim can survive summary judgment motion to dismiss. However, there is no clear law on how to plead a case for a MHPAEA violation, and most cases thus far have been fact-specific and limited only to the plan that was in question in each instance. Moreover, because there are no clear guidelines defining

the scope of what constitutes a violation of the MHPAEA, the existing landscape of case law is a wide and scattered array of holdings that indicate whether or not a specific plan's specific QTL or NQTL violates mental health parity laws instead of offering anything more comprehensive.

The problem of suicide is a complex problem, and mental health parity laws are only a part of the solution. Even then, parity laws are limited by questions of scope, coverage, and cost. However, increasing mental health care access and utilization can potentially decrease suicide rates, and policy changes can be made to existing mental health parity laws to help increase access. The law can increase mental health care access by eliminating legal barriers to care. This can be done by overturning the Second Circuit so that psychiatric providers are able to bring suit on behalf of their patients, identifying one pleading standard to apply to all MHPAEA cases, creating a comprehensive definition as to the scope of mental health care, and by enacting laws such as the BHCTA that could increase transparency in health care plans and plan administration.