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Mental Health Parity: The Patient Protection and Affordable Care Act and the Parity Definition Implications

Suann Kessler

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Mental Health Parity: The Patient Protection and Affordable Care Act and the Parity Definition Implications

by SUANN KESSLER*

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Introduction

At least twenty-eight percent of American adults suffer from a mental or addictive disorder.¹ Thus, it may seem surprising that attempts to establish federal guidelines for mental health services under health insurance plans did not take place until the 1970s.² Yet the fact that health insurance coverage for mental health services differs drastically from that of other medical services is not as startling when taking into account mental health's history, and its complete

* J.D. Candidate, University of California, Hastings College of the Law, 2014. The author thanks Professor Robert Schwartz for all of his guidance and support.

1. Aviv Shamash, *A Piecemeal, Step-by-Step Approach Toward Mental Health Parity*, 7 J. HEALTH & BIOMED. L. 273, 276 (2011).

2. *Id.*

isolation from the medical field.³ Although it has yet to achieve parity with other medical services, health insurance coverage for mental health services has improved over time. Because of the unfair and unequal treatment that has evolved between insurance coverage of mental health services and other medical services, parity refers to, among other things, the equalization of the reimbursement rates for these services.⁴ Because the recent enactment of the Patient Protection and Affordable Care Act (“PPACA”) appears to have filled the parity gaps left by the Mental Health Parity and Addiction Equity Act of 2008, many claim that mental health parity has finally been achieved.

While the PPACA may superficially appear to have plugged all the gaps, the ultimate questions are whether it provides actual mental health parity, and whether it facilitates access to mental health services for those who truly need them. A deeper look reveals it may fall short of providing actual parity between mental health and other medical services. Responses to the new PPACA provisions also cast doubt on whether parity has been achieved. For example, insurance companies have begun implementing nonreimbursement policies for mental health services that do not trigger the parity requirements of the PPACA. In light of the ever-changing and advancing health care market, evaluation of parity in mental health services requires a more sophisticated analysis. The question of parity in mental health services requires answering two essential questions. First, how should parity be defined in the current health care market? Second, besides financial and treatment limitations, should other factors now be included in evaluating parity?

Part I of this note will track the history of mental illness as well as describe how America initially attempted to treat these illnesses. Part I will also touch upon the suggestion that beliefs about the causes of mental illnesses contributed not only to the disparate kinds of treatment received by the mentally ill, but also to the delay of federal legislation mandating mental health parity. Part II will identify the major factors that have limited Americans’ access to mental health services, and which ultimately motivated the enactment of legislation mandating mental health parity. Part III will discuss parity

3. John Mauldin, *All Smoke and No Fire? Analyzing the Potential Effects of the Mental Health Parity and Addiction Equity Act of 2008*, 35 LAW & PSYCHOL. REV. 193, 196-97 (2011).

4. Amanda Clark, *The Patient Protection and Affordable Care Act and Efforts of the Mentally Ill to Achieve Equal and Adequate Health Care Coverage*, 88 U. DET. MERCY L. REV. 357, 358 (2010).

advancements and failures associated with each of the following three acts: the Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act of 2008, and the Patient Protection and Affordable Care Act. Part IV will address the problems that arise from the narrow definition of parity in today's health insurance plans. Part V will propose a solution to this parity definition issue, and Part VI concludes.

I. Brief History of Mental Illness

The discovery of skulls with burr-like holes from as early as 5,000 B.C. suggests that the treatment of mental illnesses has occupied human beings for millennia.⁵ It is likely that humans have endured mental health problems for as long as they themselves have existed.⁶ In ancient times, the symptoms of mental illness were thought of not as illness, but rather as signs of either demonic possession, or divine punishment for devious behavior or the sins of one's parents.⁷ Even today, mental illness is still believed by some to be punishment for immoral or sinful behavior.⁸ Beliefs regarding the underlying causes of mental disorders have contributed not only to the heavy stigma attached to people who suffer from mental illness, but also to various forms of so-called "treatment," or lack thereof, that these individuals have been forced to endure.⁹

Treatment of mental illness has progressed significantly from early treatments like boring holes in patients' skulls to more modern approaches like outpatient and preventative care. Mental illness has historically been treated in many ways, including drilling holes through one's skull, performing exorcisms, purging or bleeding harmful substances out of the body, and sedating the individual.¹⁰ Starting in the 1600s, the mentally ill were locked up in asylums

5. ROY PORTER, *MADNESS: A BRIEF HISTORY* 10 (2003).

6. See Shamash, *supra* note 1, at 273 ("[M]ental illness has been present in society since ancient times").

7. See Stacey A. Tovino, *Neuroscience and Health Law: An Integrative Approach?*, 42 AKRON L. REV. 469, 475 (2009); see also PORTER, *supra* note 5, at 12 ("[C]ertain disorders were caused by spirit invasion, sorcery, demonic malice, the evil eye, or the breaking of taboos").

8. Tovino, *supra* note 7.

9. See Allison Foerschner, *The History of Mental Illness: From "Skull Drills" to "Happy Pills"*, STUDENT PULSE (Mar. 31, 2013); see also PORTER, *supra* note 5, at 15 ("The disorder was in turn countered by prayers, incantations, and sacrifices offered at temples dedicated to Asklepios, the god of healing.").

10. Foerschner, *supra* note 9.

because society deemed them too dangerous to the public.¹¹ In the United States, incarceration of the mentally ill began in the 1840s.¹² Worse still, the great majority of asylums, institutions, and prisons severely abused the mentally ill by subjecting them to such inhumane treatment as chaining them to walls like animals.¹³ Electroshock therapy, lobotomies, therapeutic asylums, and psychiatric drugs were also incorporated as methods to cure mental disease.¹⁴ By the 1940s, taxed by the rising number of committed patients, in conjunction with systematic understaffing and underfunding, institutions and asylums for the treatment of the mentally ill were dilapidated and further deteriorating.¹⁵ For several reasons, the 1950s saw a radical shift in public perception of mental illness and how it should be treated.¹⁶ Part of this change was a response to the overcrowding of state mental institutions, but World War II, the expansion of federal welfare programs, and other social events all contributed to a nationwide movement called deinstitutionalization, under which the mentally ill were released back into society.¹⁷ Outpatient care became the preferred treatment for individuals with a mental disorder, along with an emphasis on preventive care.¹⁸

Private health insurance had emerged earlier, the early 1930s, with employer-sponsored health insurance developing not long after.¹⁹ However, because outpatient mental health services were not an option until the 1960s, private health insurance companies rarely covered these services.²⁰ Provision of mental health services has historically been regarded as the province of the states, and even after

11. See EDWARD SHORTER, *A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC* 154 (1998).

12. *Timeline: Treatments for Mental Illness*, PBS, <http://www.pbs.org/wgbh/amex/nash/timeline/index.html> (last visited Mar. 31, 2013).

13. *Id.*

14. Jonathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL'Y 181, 198 (2012); Shamash, *supra* note 1, at 273.

15. Fish, *supra* note 14, at 197; see also *Timeline: Treatments for Mental Illness*, *supra* note 12, ("In the United States, the number peaks at 560,000 in 1955.").

16. Mauldin, *supra* note 3, at 194.

17. See Shijie Feng, *Madness and Mayhem: Reforming the Mental Health Care System in Arizona*, 54 ARIZ. L. REV. 541, 545-46 (2012); see also *Timeline: Treatments for Mental Illness*, *supra* note 12, ("The number of institutionalized mentally ill people in the United States will drop from a peak of 560,000 to just over 130,000 in 1980.").

18. Mauldin, *supra* note 3, at 194.

19. David Blumenthal, *Employer-Sponsored Health Insurance in the United States – Origins and Implications*, 355 NEW ENG. J. MED. 82, 83 (2006).

20. See Fish, *supra* note 14, at 210.

the advent of private health insurance states continued to provide the majority of funding for mental health services.²¹ It was not until the mid-20th century that the federal government began to expand its role in taking care of the mentally ill.²² For instance, in 1946, President Truman signed into law the National Mental Health Act (NMHA), which created the National Institute of Mental Health.²³ The NMHA encouraged the training of mental health professionals and mental health research by providing federal financial assistance.²⁴ Furthermore, in 1965, the federal government created Medicaid and Medicare, both of which offered public health insurance coverage for mental health services.²⁵

The twentieth century also witnessed the emergence of modern psychiatry.²⁶ Psychiatry was long regarded as a pseudo-science like alchemy.²⁷ Initial skepticism toward psychiatry most likely was due to the fact that the origin and biological processes of mental disorders were largely unknown.²⁸ Eventually, with the publishing of the third revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, the medical field legitimized the practices of psychiatry and psychology.²⁹ Acceptance of psychiatry and psychology as legitimate branches of medicine has led to increased acceptance and awareness of mental illnesses as well.³⁰

Nevertheless, stigmatization of the mentally ill continues to persist in America.³¹ Because the majority of mental disorders do not have readily observable symptoms, some see these disorders as “lesser” illnesses.³² Such beliefs perpetuate the stigma against the mentally ill, and lead many to question whether claims for insured mental health treatments are meritorious.³³ This stigmatization

21. Fish, *supra* note 14, at 200.

22. *Id.*

23. *Id.*

24. *Id.*

25. Olukunle Fadipe, *Affordable Mental Health Care in the Post Healthcare Reform Era*, 57 WAYNE L. REV. 575, 578 (2011).

26. PORTER, *supra* note 5, at 9.

27. *Id.* at 1.

28. Fish, *supra* note 14, at 183.

29. *See id.* at 186-210 (discussing the history of psychiatry).

30. *Id.* at 245.

31. *See* Clark, *supra* note 4, at 357.

32. DAVID CUTLER, *YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM* 33 (2005).

33. Mauldin, *supra* note 3, at 193.

manifests through discrimination against the mentally ill on many fronts, including in social interactions, access to housing, access to health care, and employment.³⁴ Many authorities have identified the stigma against mental illness as one of the principal reasons for limited funding for mental health research, lack of parity in public and private health insurance coverage, and lack of available and reimbursable treatments for mental illnesses.³⁵ In light of the history of mental health treatment in the United States, it is not surprising that federal legislation mandating parity with regards to insurance coverage of mental health services was not passed until 1996.

II. Before Mental Health Parity Legislation

Several major flaws in public health insurance coverage of mental health services have historically limited access to mental health care in the United States. First, at a basic level, it has been extremely difficult to gain access to public insurance programs because of their strict eligibility requirements.³⁶ For example, to be eligible for Medicare, one must be over sixty-five years of age or disabled and receiving Social Security Disability Insurance benefits.³⁷ To be eligible for Medicaid, one must be considered to be part of the “deserving poor.”³⁸ That is, one must have a good justification for being poor.³⁹ Being part of the “deserving poor” means fitting into one of the following categories: “the elderly, disabled, blind, children, parents, and pregnant women.”⁴⁰

The division of Medicaid funding between the federal governments and the states has also contributed to difficulties in getting access to mental health services.⁴¹ Because each state has defined mental illness in its own terms, mental health coverage under

34. Shamash, *supra* note 1, at 273-74; *see also* Clark, *supra* note 4, at 357 (“Those suffering from mental illnesses have been stigmatized in all aspects of their lives by peers, businesses, media, and insurance companies.”).

35. *See* Tovino, *supra* note 7.

36. *See* BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 597 (6th ed. 2008).

37. Fadipe, *supra* note 25.

38. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH CARE REFORM: SUPPLEMENTARY MATERIALS* 229 (2012 ed. 2012).

39. *Id.*

40. *Id.*

41. *Id.*

Medicaid is neither uniform nor consistent across the country.⁴² Under Medicaid, definition of mental illness is critical in determining which mental disorders were and were not covered.⁴³ As a result, each state's Medicaid program covered different mental disorders and to varying degrees.⁴⁴

Employer-sponsored private insurance is the next largest source of insurance coverage after public health insurance programs.⁴⁵ Like the public programs, employer-sponsored plans have had restrictions that limit access to mental health services. First, like the states under Medicaid, employer-sponsored insurers decide how mental illness will be defined.⁴⁶ As a result, individuals with employer-sponsored insurance have faced the same problems as Medicaid-eligible individuals stemming from inconsistent coverage of mental health services.⁴⁷ Second, private insurers could choose not to offer mental health coverage,⁴⁸ although most employer-sponsored insurance plans have in fact offered some form of coverage for mental health services.⁴⁹ However, insurers have treated coverage of mental health services separately from coverage for other illnesses, by having independent requirements.⁵⁰ Consequently, what mental health coverage has been offered has carried with it higher premiums, fewer services, and shorter coverage periods than for other medical services.⁵¹

Another problem has been inflated health care spending in the United States, with the country spending "more dollars and the highest percentage of gross domestic product (GDP) of any nation on

42. See Sara Nadim, *The 2008 Mental Health Parity and Addiction Equity Act: An Overview of the New Legislation and Why an Amendment Should be Passed to Specifically Define Mental Illness and Substance Use Disorders*, 16 CONN. INS. L.J. 297, 312 (2009).

43. See *id.* at 312-13.

44. See *id.*

45. Fadipe, *supra* note 25, at 579.

46. *Id.* at 578.

47. See *id.*

48. *Id.* at 579.

49. *Id.*

50. Mauldin, *supra* note 3.

51. Fadipe, *supra* note 25, at 579; see also Nadim, *supra* note 42, at 300 ("In the 1990's, the majority of employer-sponsored health plans that did include mental health services placed far greater restrictions on mental health services than for other medical services. In 1998, sixty-two percent of health plans imposed limits on inpatient treatment for mental health services and fifty-seven percent imposed limits on outpatient treatment. These limits were imposed purely on mental health services and typically not placed on other medical services.").

health care.”⁵² In addition, mental health care costs have risen over time as well, with inpatient psychiatric care costs significantly increasing from \$3 billion in 1969 to \$21 billion in 1986.⁵³ Unfortunately, the astounding climb in overall health care costs has not resulted in an equivalent rise in the quality of care. Despite vastly increased spending, in 2000 the United States ranked only thirty-seventh worldwide in overall health system performance.⁵⁴ Recently, the idea of managed care has spread in the health care market as a structure for insurers to utilize to reduce costs and increase quality of care.⁵⁵ The introduction of managed care saw mental health services offered on a level that approached parity with other health care services.⁵⁶ Yet health costs continued to rise,⁵⁷ and in response, insurance companies began cutting comprehensive mental health plans.⁵⁸ The access-limiting adjustments that insurers imposed included “increased deductibles, reduced maximum inpatient days and outpatient visits covered annually, and decreased lifetime and annual limits.”⁵⁹ Thus, despite brief hopes that managed care would result in parity for mental health services, coverage remained far below that for other medical services.

III. Mental Health Parity Legislation

Before mental health parity legislation was introduced, some turned to the courts in efforts to receive mental health benefits on par with other medical benefits.⁶⁰ Similarly to how the states had adopted divergent definitions of mental illness, courts reached drastically different results in resolving these claims.⁶¹ Interestingly, plaintiffs were more likely to succeed when the courts focused on the disorder’s symptoms instead of the disorder’s biological origins.⁶² Similarly, courts found in favor of plaintiffs when they classified the condition

52. Glen Cheng, *The National Residency Exchange: A Proposal to Restore Primary Care in an Age of Microspecialization*, 38 AM. J. L. AND MED. 158, 160 (2012).

53. Shamash, *supra* note 1, at 277.

54. Cheng, *supra* note 52.

55. Shamash, *supra* note 1, at 277.

56. *Id.*

57. *Id.*

58. *Id.*; Tovino, *supra* note 7, at 489.

59. Shamash, *supra* note 1, at 277.

60. *Id.* at 279.

61. *Id.*

62. *Id.*

as a physical impairment, as opposed to a mental impairment.⁶³ Unfortunately, the stigma attached to mental illness was prevalent in court proceedings as well. In order to try to solve this judicial inconsistency, fifteen states each passed some sort of law addressing mental health parity before 1996.⁶⁴

However, the ubiquity of mental health disorders—affecting one in four adults in 2010, totaling approximately 57.7 million Americans—and the costs associated with this prevalence, meant that if significant and wide-reaching changes in coverage of mental health services were to be realized, mental health parity at the federal level would be required.⁶⁵ In 1992, Senators Pete Domenici and John Danforth drafted the first national bill focused on mental health parity, which advocated change through the “indirect mechanism of insurance regulation.”⁶⁶ Although the bill was unfortunately scuttled early on, the fact that it was introduced provided evidence that views were shifting and federal legislation would be forthcoming.⁶⁷

A. Mental Health Parity Act of 1996

In response to the growing urgency for mental health parity, Senators Domenici and Paul Wellstone proposed a mental health parity amendment to the Kassebaum-Kennedy bill for health care portability, also known as the Health Insurance and Portability and Accountability Act of 1996 (“HIPAA”).⁶⁸ After passing the Senate, the proposed amendment to HIPAA was met with criticism in the House concerning whether it would result in health insurance premium increases.⁶⁹ In order to pass HIPAA promptly, Senators Nancy Kassebaum and Ted Kennedy chose to delete the proposed amendment from the bill.⁷⁰ Determined to secure passage of the mental health parity amendment, Senators Domenici and Wellstone then decided to attach the amendment to the Employee Retirement

63. See Shamash, *supra* note 1, at 279.

64. See Fadipe, *supra* note 25, at 580.

65. *Mental Illness: Facts and Number*, NAT’L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53155 (last visited Mar. 31, 2013); Fadipe, *supra* note 25, at 592 (“One study estimates the cost of serious mental illness to the nation at \$193.2 billion a year.”).

66. Mauldin, *supra* note 3.

67. *Id.*

68. Nadim, *supra* note 42, at 300.

69. *Id.*

70. *Id.*

Income Security Act of 1974 and the Public Health Services Act.⁷¹ The amendment was yet again met with much opposition in the House over potential costs.⁷² As a consequence, the final version of the amendment, known as the Mental Health Parity Act of 1996 (“MHPA”), bore little resemblance to the original amendment and ultimately did little to advance mental health parity.⁷³

The greatest impact on mental health parity wrought by the MHPA came as a result of its restriction on insurance companies’ ability to set unequal annual and lifetime aggregate spending limits on mental health services as compared to other medical services.⁷⁴ However, this prohibition, or parity mandate, was severely confined by several qualifications built into the MHPA.⁷⁵ First, and most importantly, the prohibition against disparate annual and lifetimes caps only applied to insurers that included mental health services in their benefits package.⁷⁶ Because the MHPA contained no requirement that health insurance plans must include mental health benefits,⁷⁷ insurers had the legally available option of completely dropping coverage of mental health services if they did not want to comply with the MHPA’s limited parity mandate.⁷⁸ Second, the MHPA afforded these health plans an “opt-out of parity” provision if the cost of providing parity raised overall plan costs more than one percent.⁷⁹ Third, the parity mandate “did not extend to substance abuse treatments.”⁸⁰ Finally, the MHPA granted small employers, defined as having fifty or fewer employees, an exception to the parity mandate.⁸¹ Consequently, the mental health parity mandate created by the MHPA was extremely limited and far from comprehensive.⁸²

The MHPA’s mental health parity mandate was also deficient because it permitted insurers to discriminate against the mentally ill

71. Nadim, *supra* note 42, at 300.

72. *Id.*

73. Shamash, *supra* note 1, at 280.

74. *Id.* at 281.

75. *See* Shamash, *supra* note 1, at 281.

76. Fadipe, *supra* note 25, at 580.

77. Shamash, *supra* note 1, at 282.

78. *See id.* at 282-83 (“The modest cost increases that resulted from compliance with the MHPA provided an explanation as to why less than one percent of insurers dropped mental health benefits in reaction to the legislations.”).

79. Clark, *supra* note 4, at 363.

80. Tovino, *supra* note 7, at 490.

81. Fish, *supra* note 14, at 211.

82. *Id.* at 212.

through other means.⁸³ For instance, large-group health plans were allowed to block patient access to out-of-network mental health providers, and these plans could impose disparate restraints on deductibles, co-payments, premiums, and number of visits covered for mental health services.⁸⁴ Furthermore, since the MHPA did not provide a standard definition of mental health, insurers could pick and choose which mental illnesses they wanted to cover based on their definition of mental health.⁸⁵ Finally, the MHPA also contained a sunset provision which completely eliminated the parity requirements by 2006.⁸⁶ As might be expected of a statute fraught with loopholes, insurance companies exploited the technicalities in the MHPA in order to comply with the parity mandate instead of increasing mental health coverage.⁸⁷ The American Psychological Association stated in a 2002 report that eighty-seven percent of employers who complied with the parity mandate decided to reduce the mental health benefits not controlled by the MHPA, which effectively rendered “the effects of the law moot.”⁸⁸ In sum, the MHPA accomplished very little in changing scope of coverage for mental health services at the national level.⁸⁹

After the failure of the MHPA, Congress considered several similar versions of the Mental Health Equitable Treatment Act (“MHETA”), which sought to eliminate the weaknesses of the MHPA.⁹⁰ However, each of these acts, the MHETA of 1999, the MHETA of 2001, the MHETA of 2002 and the MHETA of 2003, would ultimately be unsuccessful in becoming law.⁹¹

B. Mental Health Parity and Addiction Equity Act of 2008

Senators Domenici and Wellstone persisted in their efforts to pass a full and comprehensive mental health parity mandate.⁹² Along

83. See Fish, *supra* note 14, at 211.

84. Clark, *supra* note 4, at 363; Fadipe, *supra* note 25, at 580.

85. Shamash, *supra* note 1, at 282.

86. Tovino, *supra* note 7, at 490-91.

87. Desiree Busching & Simon Kapochunas, *Timothy's Law: Introducing New York to Mental Health Parity*, 25 HOFSTRA LAB. & EMP. L.J. 601, 617 (2008).

88. *Id.*

89. Mauldin, *supra* note 3, at 199.

90. Busching & Kapochunas, *supra* note 87 (“intended ‘to provide for full parity with respect to health insurance coverage for certain severe biologically based mental illnesses and to prohibit limits on the number of mental-illness-related hospital days and outpatient visits that are covered for all mental illnesses.’”).

91. *Id.* at 617-18.

92. Nadim, *supra* note 42, at 304.

with these senators' unwavering determination, five significant advances factored into the increased support for, and successful passage of, the Mental Health Parity and Addiction Equity Act in 2008.⁹³ First, scientific research finally affirmed that there were biological bases and effective treatments for many mental illnesses.⁹⁴ Second, as a result of troops returning from the Middle East with serious mental illnesses, the stigma towards mental illness began to wane.⁹⁵ Third, employers started noticing that employees who received mental health services missed fewer days at work, whereas a lack of mental health services was associated with reduced employee productivity.⁹⁶ Fourth, and of significant importance, mental health groups were able to assuage cost concerns associated with providing mental health parity.⁹⁷ Finally, "the experimentation with parity at both the state level and in the health insurance program for federal employees, including members of Congress, ha[d] prove[n] workable."⁹⁸ These changes in public perception of mental illnesses ultimately resulted in Congress enacting an amendment to the MHPA as part of the Emergency Economic Stabilization Act of 2008.⁹⁹ This amendment, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), was projected to enhance coverage of mental health services for 113 million people.¹⁰⁰

The MHPAEA augmented the MHPA's parity mandate by decreeing that group health plans could no longer contain more restrictive financial and treatment limits for mental health services than for all other medical services.¹⁰¹ The MHPAEA prohibited financial limitations like separate cost sharing requirements for only mental health benefits, as well as specifically stating that parity must exist in "deductibles, copayments, coinsurance, and out-of-pocket

93. See Nadim, *supra* note 42, at 304-05.

94. *Id.*

95. *Id.* at 305-06.

96. *Id.*

97. *Id.* at 304-05 ("A 2006 study in the New England Journal of Medicine found that insurers' costs rose less than half a percentage point when full parity was required for federal workers starting in 2001. The Congressional Budget Office Cost Estimate also stated that if the more generous House bill were enacted, the costs for premiums would increase for group health insurance by an average of only about 0.4 percent.").

98. *Id.* at 306.

99. Fadipe, *supra* note 25, at 581.

100. Nadim, *supra* note 42, at 306.

101. Shamash, *supra* note 1, at 284.

expenses” for medical services and mental health services.¹⁰² To prevent treatment limitations, the MHPAEA forbade insurers from setting disparate treatment stipulations on mental health services, including “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.”¹⁰³ Parity was also prescribed for access to out-of-network mental health providers.¹⁰⁴ In addition, the MHPAEA explicitly included substance use disorder benefits in its expanded parity mandate.¹⁰⁵ And because the MHPA’s sunset clause had generated numerous fears and doubts regarding the lifetime of its limited parity mandate, the MHPAEA’s drafters purposefully omitted a sunset provision.¹⁰⁶

Regrettably, the MHPAEA suffered from the same essential defect as the MHPA: the parity mandate did not require insurers to cover mental health services at all.¹⁰⁷ In other words, the MHPAEA’s mental health parity provisions only pertained to insurers who provided coverage of mental health services, which they were not required to do under the law.¹⁰⁸ Moreover, the MHPAEA’s parity mandate did not apply to small employers with 50 or fewer employees.¹⁰⁹ Again like the MHPA, the MHPAEA provided insurers with a cost exemption, which stated that insurers did not have to comply with the parity mandate “if the overall implementation of the bill would result in an increased cost of two percent or more during the first year after the legislation goes into effect and one percent in the following years.”¹¹⁰ Because the MHPAEA lacked specific definitions of mental and substance use disorders, it again allowed insurers to determine which mental illnesses to cover and which to not.¹¹¹ The MHPAEA also continued

102. 42 U.S.C.A. § 300gg-5(a)(3) (West Supp. 2009); Nadim, *supra* note 42, at 306.

103. 42 U.S.C.A. § 300gg-5(a)(3)(B)(iii); Nadim, *supra* note 42, at 306-07.

104. Shamash, *supra* note 1, at 285.

105. *Id.*

106. See Mauldin, *supra* note 3, at 200.

107. Shamash, *supra* note 1, at 286.

108. Fadipe, *supra* note 25, at 581.

109. Fish, *supra* note 14, at 213; see also Shamash, *supra* note 1, at 306 (“the Equity Act’s small employer exemption will significantly limit the Act’s effectiveness. As of 2009, approximately 170 million individuals obtained insurance through an employment based insurance plan, making an employer the most likely source of health insurance. Furthermore, roughly forty-three of employees in the United States work for a small employer”).

110. Nadim, *supra* note 42, at 307.

111. *Id.* at 308.

to permit insurers to establish their own definitions of what would be considered a medical necessity, further empowering insurers to pick and choose which mental illnesses to cover.¹¹² However, the MHPAEA did to slightly reel in this practice by mandating that insurers publically release the criteria used in making medical necessity determinations.¹¹³ All in all, the MHPAEA significantly expanded the parity mandate found in the MHPA, but left in place many loopholes through which insurers could avoid having to provide full mental health parity.¹¹⁴

C. Patient Protection and Affordable Care Act

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act, or PPACA.¹¹⁵ The law drastically renovated the American health care system, introducing sweeping changes to the health care structure designed to control costs, expand insurance coverage, and improve the overall quality of health care in the United States.¹¹⁶ While not predominately focused on the issue of mental health parity, the PPACA, taken as a whole, ultimately strengthens mental health parity through a variety of mechanisms that will plug some of the gaps left by the MHPAEA.¹¹⁷ For instance, one of the most hotly debated provisions of the PPACA is the individual mandate, which requires all individuals to either purchase health insurance or pay a penalty.¹¹⁸ The individual mandate is projected to result in thirty-two million previously uninsured individuals obtaining health insurance coverage by 2019.¹¹⁹ The PPACA also requires the development of two types of state-based exchanges, one for individuals and one for small businesses.¹²⁰ These exchanges will serve as an easily accessible location for consumers not only to view available health insurance plans, but to select and

112. Mauldin, *supra* note 3, at 200.

113. *Id.*

114. *See id.* at 201 (“One study found that of the 31% of firms bound by the MHPAEA that made changes to their mental coverage following passage of the law, only 5% cut mental health coverage altogether to achieve compliance.”).

115. *Summary of New Health Reform Law*, KAISER FAMILY FOUNDATION, 1, <http://www.kff.org/healthreform/upload/8061.pdf> (last modified Apr. 15, 2011).

116. *Id.*

117. *See* Mauldin, *supra* note 3, at 205.

118. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S.Ct. 2566, 2601 (2012) (“The Federal Government does have the power to impose a tax on those without health insurance.”); Shamash, *supra* note 1, at 294.

119. Shamash, *supra* note 1, at 294-95.

120. *Summary of New Health Reform Law*, *supra* note 115.

purchase a suitable policy.¹²¹ For low income individuals, defined as incomes below 400% of the Federal Poverty Level, “premium and cost-sharing credits” will be available to offset the costs of purchasing health insurance plans from the exchanges.¹²²

The majority of the new plans, including those from the state-based exchange, the individual market, and the small group market, will be required to cover at least the ten essential health benefits:

hospitalization, outpatient hospital and clinical services (including emergency services), physician services, medical services, preventive services, prescription drugs, rehabilitation services, maternity care, baby and child care for children twenty-one and under, early and periodic screening, diagnosis and treatment for children up to age 21, and mental health, behavioral health and substance use services.¹²³

All of the plans that must comply with the PPACA’s essential health benefits requirement by covering mental health services must also comply with the MHPAEA’s mental health parity mandate.¹²⁴ As a result, the PPACA will interact with the MHPAEA’s mental health parity mandate by transforming it into an actual mandate for most insurance plans, and will also extend the MHPAEA’s parity mandate to some individuals who were previously out of reach.¹²⁵

The PPACA provides several other key benefits that will impact the provision of mental health services. A major provision of the PPACA prohibits insurance companies from discriminating against and denying coverage to individuals with preexisting conditions, including mental disabilities and substance abuse disorders.¹²⁶ The PPACA expands access to health care by allowing dependents to remain on their parents’ health insurance plan until the age of twenty-six.¹²⁷ Finally, the PPACA sets aside money to train mental health professionals, and to create intervention programs, school-based health clinics and community mental health centers.¹²⁸

As for public insurance, the PPACA affords states the opportunity to choose whether or not to expand their Medicaid

121. *Summary of New Health Reform Law*, *supra* note 115.

122. *Id.* at 1-2.

123. Clark, *supra* note 4, at 370; Shamash, *supra* note 1, at 296.

124. Shamash, *supra* note 1, at 317 (“PPACA explicitly requires that health plans comply with the provision of the Equity Act”).

125. *See* Mauldin, *supra* note 3, at 206.

126. *Id.*

127. Lawrence G. Smith & Megan Anderson, *New Direction in American Health Care: Innovations from Home and Abroad*, 39 HOFSTRA L. REV. 23, 32 (2010).

128. Cheng, *supra* note 52, at 179-80; Fish, *supra* note 14, at 217.

programs to include all childless and non-disabled individuals under the age of 65 who have incomes up to 138% of the Federal Poverty Level.¹²⁹ If a state elects to expand their Medicaid program, then the state must provide the expanded Medicaid population with coverage that includes at least the ten essential health benefits.¹³⁰ The PPACA expressly states that insurance plans must provide mental health benefits at parity to the medical and surgical benefits.¹³¹ The PPACA also creates and finances new enterprises that will enable psychologists to engage in “community interdisciplinary teams that promote primary care,” as well as participate in teams of health providers who deliver integrated services to low income individuals.¹³² The PPACA’s Medicaid expansion is estimated to open up mental health and substance abuse services and prescription drug coverage to an additional sixteen million people by 2019.¹³³ The PPACA also grants states the option to administer home health services for “individuals with chronic conditions, [including] ‘persistent mental health conditions.’”¹³⁴

Despite all of the promising changes under the PPACA, questions about mental health parity remain. Insurance companies are currently in the process of adjusting their old plans, or developing new ones, to comply with the PPACA. Thus, although the end results are not yet completely realized, the provisions which attempt to fill gaps in mental health parity provisions appears as if they may fall short in several ways. One particular failure of the PPACA is that it exempts grandfathered individual and employer-sponsored plans from covering the essential benefits package, including mental health services.¹³⁵ Thus, these plans will only have to comply with the MHPAEA’s parity mandate if they provide coverage for mental

129. Sebelius, *supra* note 118, at 2607 (“What Congress is not free to do is to penalize States that choose not to participate in that new [expansion] program by taking away their existing Medicaid funding.”); *Medicaid: A Primer: Key Information on the Nation’s Health Coverage Program for Low-Income People*, KAISER FAMILY FOUNDATION, 16 (Mar. 1, 2013), <http://www.kff.org/medicaid/upload/7334-05.pdf>.

130. *Medicaid: A Primer: Key Information on the Nation’s Health Coverage Program for Low-Income People*, *supra* note 129, at 18.

131. Leslie Prentice, “At Risk for Incarceration”: *Women in Poverty, Post-Traumatic Stress Disorder, and Medicaid*, 32 WOMEN’S RTS. L. REP. 81, 96 (2010).

132. *Id.* at 96; *see also* Shamash, *supra* note 1, at 300 (“One preventive strategy the Task Force recommended, and therefore PPACA mandated, is the integration of mental health and substance abuse care with primary care.”).

133. Fish, *supra* note 14, at 215-16.

134. Fadipe, *supra* note 25, at 585.

135. *Summary of New Health Reform Law*, *supra* note 115, at 6.

health services. The PPACA also continues to exempt small employers from the mental health parity mandate, even though the small employers still may be required to provide the PPACA's essential health benefits.¹³⁶ Another problem in the small employer provisions is that the PPACA defines small employers as having between one and one hundred employees, which is inconsistent with the MHPAEA's definition of between two and fifty employees.¹³⁷ Consequently, only small employers who have between fifty-one and one hundred employees will have to observe the MHPAEA's mental health parity mandate.¹³⁸

Because the PPACA's requirements do not extend to all insurance policies, many health care providers will continue to exclude expensive mental health treatments from the "lower level coverage plans."¹³⁹ Individuals with serious mental illnesses may not receive the type of treatment that they need if they can afford only such "lower level coverage plans," which will only offer basic mental health benefits.¹⁴⁰ The PPACA also fails to establish a definition for mental illness, and to list the "minimum level of mental health services that must be covered by all insurance plans."¹⁴¹ Analysts believe that because of these deficiencies, twenty-three million people will not be able to afford the health services that they need when the PPACA has taken complete effect in 2019.¹⁴²

IV. Mental Health Parity Issue

As discussed above, the PPACA fails to resolve problems of mental health parity in several respects.¹⁴³ Although the PPACA moves things forward, the United States still has a long road ahead to establish a full and comprehensive mental health parity mandate. Furthermore, new insurance company practices threaten what advances the PPACA has made in achieving mental health parity. Due to "data indicat[ing] a positive correlation between behavioral [mental health] insurance parity and . . . [the] over-use of other physical health insurance benefits[.]" insurance companies now

136. Mauldin, *supra* note 3, at 106; Shamash, *supra* note 1, at 319.

137. Shamash, *supra* note 1, at 319-20.

138. *Id.*

139. Fadipe, *supra* note 25, at 589.

140. *Id.*

141. *Id.* at 592.

142. *Id.* at 590.

143. *See supra* Part IV.C.

realize that people who seek psychiatric help tend to have more physical problems than people who did not seek psychiatric help.¹⁴⁴ Because they require more mental health services as well as other medical services, it necessarily follows that those who seek psychiatric treatment will cost insurance companies more than those who do not seek psychiatric help.

In order to discourage people who seek psychiatric help from signing on to one of their health plans, insurance companies have started utilizing a practice that requires individuals to work their way up a hierarchy of mental health care professionals, referred to in this note as a “mental health tree.” Instead of immediately offering access to mental health care professionals, insurance companies ask that individuals attempt to get the mental health care that they need through their general practitioner, or primary-care physician first.¹⁴⁵ If a general practitioner cannot help, then a referral is made to a mental health care professional.¹⁴⁶ There are many different types of mental health care professionals, including psychiatrist, mental health nurse practitioner, clinical psychologist, clinical social worker, mental health counselor, family therapist, peer specialist, and others,¹⁴⁷ each of which costs the insurance companies a different price.¹⁴⁸ To reduce costs and increase profits, insurance companies prefer individuals to first utilize lower cost mental health care services before higher cost services, and thus referrals to psychiatrists are lower.¹⁴⁹ For example, a plausible treatment scenario is as follows. An individual who needs mental health care may first be required to talk with a general practitioner. If the general practitioner believes that the individual

144. Lorraine Schmall, *One Step Closer to Mental Health Parity*, 9 NEV. L.J. 646, 665 (2009).

145. Michelle Andrews, *For people with mental health problems, care can be elusive*, L.A. TIMES, March 21, 2011, <http://articles.latimes.com/2011/mar/21/health/la-he-healthcare-mental-health-20110321>.

146. *Id.*; see also *What do I need to know about my insurance benefits?*, MENTAL HEALTH AMERICA, <http://www.mentalhealthamerica.net/insurance-questions> (last visited Apr. 6, 2014).

147. William N. Robiner, *The mental health professions: Workforce supply and demand, issues, and challenges*, 26 *Clinical Psychology Review* 600, 603-12 (2006); see also *Types of Mental Health Professionals*, MENTAL HEALTH AMERICA, <http://www.mentalhealthamerica.net/types-mental-health-professionals> (last visited Apr. 6, 2014).

148. Robiner, *supra* note 147, at 614-15.

149. *Id.*; David E. Grembowski, Diane Martin, Donald L. Patrick, Paula Diehr, Wayne Katon, Barbara Williams, Ruth Engelberg, Louise Novak, Deborah Dickstein, Richard Deyo & Harold I. Goldberg, *Managed Care, Access to Mental Health Specialists, and Outcomes Among Primary Care Patients with Depressive Symptoms*, 17 *J. of GEN. INTERNAL MED.* 258, 262 (2002).

should see a mental health care professional, then the individual will be referred, most likely, to a therapist. Only if the therapist sees no improvement in the individual will the individual have a chance at a referral to a psychologist or psychiatrist. This practice subjects patients to seemingly endless and taxing exchanges of personal information to one mental health professional after another.

The effect of this type of referral tree is to encourage those who desperately need psychiatric help to sign up with other insurance companies. This new practice introduces another factor that may be relevant in evaluating mental health parity.

V. Possible Solutions to the Mental Health Parity Issue

Parity has traditionally been defined in terms of financial requirements and initial treatment.¹⁵⁰ Debates over the definition of parity have never factored in referrals, nor have they referred to the different kinds of mental health specialists. In order to determine whether these factors need to be included in a definition for parity, it will be necessary to assess the structure of the medical services to which mental health services are being compared. For physical ailments in today's health care system, primary care physicians generally serve as patients' "first contact" with the medical community.¹⁵¹ If a primary care physician cannot provide a patient adequate treatment, the primary care physician will refer the patient to a specialist who is trained to handle specific health problems.¹⁵² Usually, there is only one stage of referral, from general practitioner to specialist.¹⁵³ Patients almost never are referred from specialist to specialist.¹⁵⁴

The referral process for physical ailments is a relatively novel practice.¹⁵⁵ The technological advancements of the twentieth century gave rise to health specialists, including the various types of mental health specialists.¹⁵⁶ Furthermore, managed care has played a

150. See Clark, *supra* note 4, at 363.

151. *Primary Care*, AMERICAN ACADEMY OF FAMILY PHYSICIANS, <http://www.aafp.org/online/en/home/policy/policies/p/primarycare.html> (last visited Mar. 31, 2013).

152. Cheng, *supra* note 52, at 165.

153. Caroline Y. Lin, *Improving Care Coordination in the Specialty Referral Process Between Primary and Specialty Care*, 73(1) N.C. MED. J. 61, 61 (2012), available at <http://www.ncmedicaljournal.com/wp-content/uploads/2012/01/73115-web.pdf>.

154. *Id.*

155. Cheng, *supra* note 52, at 168.

156. See *id.* at 160-61.

significant role in “how patients seek specialty care.”¹⁵⁷ As mental health parity is striding closer and closer to becoming a reality, even if it does so haltingly, other factors need to be taken into account, most notably the ever-changing atmosphere of the medical field. If comprehensive parity is to be achieved, parity can no longer be defined solely in financial terms. Parity must be defined as closely as possible in relation to the other medical services provided. Under this definition, the emerging mental health tree practice undermines mental health parity. Accordingly, under a more comprehensive definition, parity between mental health and other medical services would require that there be only one stage of referral between mental health professionals, barring extremely serious and unique mental disorders. Because patients need not go through a cycle of several referrals in obtaining medical care for physical ailments, to achieve comprehensive mental health parity insurers should be prohibited from requiring patients to suffer through such a cycle in obtaining mental health care.

Conclusion

For thousands of years, individuals with mental illnesses have struggled to gain access to adequate treatment for their disorders. Stigmatization, beliefs concerning the underlying cause of mental illness, and the intrinsic nature of mental illness have all compounded the difficulties faced by those who suffer from mental illness. Once treatments were designed to actually assist the mentally ill in acclimating to and succeeding in life, insurers started offering mental health coverage. However, mental health coverage has never been offered on an equal basis with that for other services.

In the 1990s, a variety of factors culminated in persuading people to demand that insurance companies cover mental health services on par with other medical services. One of the most persuasive reasons was the cost to society of not treating individuals with mental health problems. For instance, in 2007 “[e]stimated costs to [the] U.S. government and businesses from untreated mental disorders [were] over \$100 billion annually in terms of lost productivity and unemployment.”¹⁵⁸ With this understanding, Congress passed the Mental Health Parity Act of 1996, and later the Mental Health Parity

157. Christopher B. Forrest & Robert J. Reid, *Passing The Baton: HMOs' Influence On Referrals To Specialty Care*, 16 HEALTH AFF. 157, 159 (1997), available at <http://content.healthaffairs.org/content/16/6/157>.

158. STEPHEN P. HINSHAW, *THE MARK OF SHAME: STIGMA OF MENTAL ILLNESS AND AN AGENDA FOR CHANGE* 179 (2007).

and Addiction Equity Act of 2008. Both of these acts constituted significant victories for mental health parity, but both ultimately failed to establish a comprehensive parity mandate for mental health services.

Enacted in 2010, the Patient Protection and Affordable Care Act both expanded access to health insurance and filled many of the parity gaps left by the MHPAEA. However, the PPACA also failed to truly achieve parity. Grandfathered individual and employer-sponsored insurance plans need not comply with the essential health benefits requirement. Both must offer mental health benefits on par with other medical benefits only if the plans offer mental health benefits in the first place. In addition, the PPACA failed to provide insurance plans with a definition for mental illness and minimum standards for what types of mental health benefits to cover.

Finally, a new issue has emerged in mental health parity. Likely as a result of studies showing that those who seek psychiatric help are more likely to consume other benefits offered under insurance plans, insurance companies have begun to require patients to climb a mental health tree for services. Because people who seek psychiatric help are more expensive for insurance companies than people who do not, insurance companies may be imposing this mental health services tree in order to discourage people who need psychiatric help from purchasing their plans in the first place. A critical question then becomes whether insurance companies who are requiring patients to see lower level mental health professionals first are in compliance with the parity mandate.

Determination of mental health parity requires examination of the medical services against which mental health services are to be compared, and the comparison must account for more than the traditional financial and treatment terms. For example, traditional physical health care services typically involve only one referral step, from primary care physician to specialist. To achieve parity, insurance companies should only be allowed to require one referral step for mental health services, not several. Accordingly, Congress must address the above-mentioned failures of the PPACA and create a rubric that accounts for the ever-changing structure of the health care field before full and comprehensive mental health parity can be realized.