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### Will Full Benefits Parity Create Real Parity? – Congress’s Second Attempt at Ending Discrimination Against Mental Illness: The Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008

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## WILL FULL BENEFITS PARITY CREATE REAL PARITY? – CONGRESS'S SECOND ATTEMPT AT ENDING DISCRIMINATION AGAINST MENTAL ILLNESS: THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2008

### INTRODUCTION

On February 5, 1963, President John F. Kennedy sent to Congress a series of proposals on mental illness.<sup>1</sup> At the top of the President's list of actions requested of every level of government, as well as private citizens, was a call "to bestow the *full benefits* of our society on those who suffer from mental disabilities."<sup>2</sup> More than forty-five years after President Kennedy sent this call to action to the members of the 88th Congress, on October 3, 2008, the 110th Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).<sup>3</sup> The new law was signed twelve years after Congress's first attempt at parity in the coverage of mental illness, the highly touted but largely unsuccessful Mental Health Parity Act of 1996 (MHPA).<sup>4</sup>

Full parity, as the term is generally understood, refers to "the equalizing of all treatment and dollar limits between medical and mental health care as well as the same co-payments and coinsurance rates."<sup>5</sup> This definition makes the term less meaningful than it should be, however. When politicians and scholars use the term "full parity," they are only referring to the benefits offered, rather than to the *offering* of benefits. That is, for an

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1. The American Presidency Project, John F. Kennedy: Special Message to the Congress on Mental Illness and Mental Retardation, <http://www.presidency.ucsb.edu/ws/index.php?pid=9546> (last visited Sept. 7, 2009) (describing "mental illness and mental retardation" as "among [the nation's] most critical health problems," and outlining the following government objectives: (1) to determine the causes of mental illness and eliminate them; (2) to strengthen resources of knowledge and skilled manpower to sustain the attack against these illnesses; and (3) to strengthen and improve programs and facilities serving the individuals suffering these diseases).

2. *Id.* (emphasis added).

3. See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Pub. L. No. 110-343, 122 Stat. 3881 (2008) (codified as amended 26 U.S.C. § 9812, 29 U.S.C. § 1185a, & 42 U.S.C. § 300gg-5).

4. See Mental Health Parity Act of 1996 ("MHPA"), Pub. L. No. 104-204, 110 Stat. 2944 (codified at 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-5).

5. Carolyn M. Levinson & Benjamin G. Druss, *The Evolution of Mental Health Parity in American Politics*, 28 ADMIN. & POL'Y MENTAL HEALTH 139, 143 (2000).

insurance policy to offer full parity in its healthcare benefits, it merely must place the same restrictions and requirements on all benefits offered, regardless of the nature of the illness or the treatment required for such illness. However, if the insurance policy fails to cover a certain type of illness or treatment regimen entirely, this does not create a lack of parity.

The MHPA failed to create any form of meaningful parity because it implicitly allowed group health plans to discriminate against mental illnesses, and it completely failed to address substance use disorders.<sup>6</sup> By enacting the MHPAEA, Congress rejected many of the flaws of the MHPA. Specifically, the MHPAEA prohibits group health plans that offer benefits for mental health and substance use disorder from placing any financial requirements on such benefits that are not placed on other healthcare benefits.<sup>7</sup> Furthermore, the new law prohibits insurance providers that offer these benefits from creating any greater treatment limitations than those required for other healthcare benefits.<sup>8</sup> However, the MHPAEA still fails to require any insurance plan to cover mental illnesses or substance use disorders.<sup>9</sup> Moreover, the law allows certain exemptions created by the MHPA to continue.<sup>10</sup> After enactment of the MHPA, almost every health insurance provider covered by the plan actively used its loopholes to continue discriminating against the mentally ill.<sup>11</sup>

While the MHPAEA only recently went into effect, and thus it is too soon to predict the effect the law will have on the disparate treatment of the mentally ill, two things are clear. First, the law is a substantial improvement on the MHPA. Second, loopholes remain, and past evidence shows that providers may exploit them, even if it means continued discrimination. This article explores the history of mental health discrimination and legislative attempts for parity on both state and federal levels. It focuses on a comparison of the MHPAEA with the MHPA. While it appears clear that the Congress has created a new law vastly superior to its prior version both in scope and in likely effect, it is clear also that the new law fails to reach far enough and will allow for continued discrimination against those suffering mental illness.

Section I of this article discusses the history of discrimination against individuals suffering mental illness, and how that discrimination led to

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6. See discussion *infra* Section II.A. (discussing the goals and failures of the MHPA).

7. See MHPAEA, Pub. L. No. 110-343, §§ 512(a)(1), (b)(1), (c)(1), 122 Stat. 3881, 3881-88; see also discussion *infra* Section IV.A. (comparing the MHPAEA with the MHPA).

8. See MHPAEA §§ 512(a)(1), (b)(1), (c)(1); see also discussion *infra* Section IV.A. (comparing the MHPAEA with the MHPA).

9. See discussion *infra* Section IV.B (discussing whether the MHPAEA can meet its goals).

10. See *id.*

11. See discussion *infra* Section II.A. (discussing how health plans continued to provide unequal coverage of mental health conditions after the MHPA).

enactment of the MHPA. This section also addresses how insurance providers have continued to discriminate against the mentally ill and how the general perception of mental illness as a disease of the mind has perpetuated bias. This perception and continued discrimination has created the need for more substantial parity legislation, and has led to the MHPAEA.

Section II reviews the steps taken to enact the MHPA as well as the goals and failures of the law. This section also discusses briefly the several attempts at enacting more meaningful legislation between the passage of the MHPA and the MHPAEA. The Section concludes by covering both sides of the main parity debate: the cost of parity.

Section III analyzes various attempts taken by state legislatures to achieve parity. The first part of this section reviews the five state laws enacted prior to the MHPA and how these statutes were more comprehensive than the original federal statute. The second part discusses the explosion of federal legislation following passage of the MHPA, what these laws sought to achieve after seeing the federal law, and why the laws were unable to reach their goals.

Section IV discusses the MHPAEA and the federal legislature's attempt to create full parity. It begins by showing how the law differs from the MHPA. This section explains why the MHPAEA represents a substantial improvement on the original law by creating full parity in benefits and how it potentially will provide better coverage for millions of Americans. The final part of this section highlights what the MHPAEA missed, including its failure to eliminate all of the loopholes created by the original law and, consequently, its failure to create true parity. It also compares the MHPAEA with the federal law that comes closest to true parity, the Federal Employees Health Benefits Program.

#### I. STIGMA – THE HISTORICAL DISCRIMINATION AND SEGREGATION OF MENTAL ILLNESS

The continued difficulty in achieving true parity for individuals suffering from mental illness, and a reason it took the United States Congress until 2008 to pass meaningful mental health parity legislation, most likely stems from a persistent belief that mental and physical health are unrelated.<sup>12</sup> This belief is also one cause of the stigmatization surrounding mental health care.<sup>13</sup> The notion of a distinction between mental and physical well-being can be traced to 17th century philosopher Rene Descartes' theories of the

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12. See Patrick J. Kennedy, *Why We Must End Insurance Discrimination Against Mental Health Care*, 41 HARV. J. ON LEGIS. 363, 364 (2004).

13. *Id.*

separation of mind and body.<sup>14</sup> Descartes conceptualized the “mind” as connected to the “spirit” and, thus, a concern of organized religion.<sup>15</sup> The “body,” on the other hand, was considered to be the concern of medical physicians, wholly separate from the mind.<sup>16</sup> As generations acknowledged and elaborated on Descartes’ views, the treatment of the mind came to be considered “non-scientific” and “non-medical,” and illnesses of the mind became regarded as failures of the individuals who suffered them, rather than treatable conditions.<sup>17</sup>

The stigma of mental illness did not begin in the 17th century, however. Early cultures interpreted the abnormal signs of mental illness as materializations of demonic possession or some different otherworldly cause.<sup>18</sup> Whatever caused mental illness and abnormality, early societies certainly did not consider issues of the mind to be issues of the body.<sup>19</sup> While this belief has been generally upheld and propagated throughout most of history, and in fact is still a point of contention today, there have been those who were willing to argue against conviction, with mixed results.<sup>20</sup>

In the United States, the colonial era urged a familial responsibility toward mental illness.<sup>21</sup> Likely due to a lack of government run institutions of any sort, the mentally ill population was considered a problem largely consigned to families.<sup>22</sup> Urbanization forced the government to confront the issue, and the several states began building institutions, first dubbed asylums

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14. U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL—EXECUTIVE SUMMARY 5 (1999) [hereinafter SURGEON GENERAL REPORT]; see also 2 The Philosophical Works of Descartes 99-100 (Elizabeth S. Haldane & G.R.T. Ross trans., 1934) (stating that the “mind can be perceived clearly and distinctly . . . [as] a complete thing without any of those forms or attributes by which we recognize that body is a substance . . . and body is understood distinctly and as a complete thing apart from the attributes attaching to the mind”).

15. SURGEON GENERAL REPORT, *supra* note 14, at 5.

16. *Id.*

17. Kennedy, *supra* note 12, at 364.

18. For example in ancient Egypt, early Greek and Roman civilizations, and Europe during the Middle Ages people believed that mental disabilities were a sign that the person was afflicted by demons. Samuel Jan Brakel, *Historical Trends, in THE MENTALLY DISABLED AND THE LAW* 9, 9-10 (1985).

19. See *id.* (describing several culture’s views of mental health, which focused on supernatural causes and solutions).

20. See WALTER J. COVILLE ET AL., ABNORMAL PSYCHOLOGY 16-17 (1960) (discussing opinions of various scientists throughout the 15th, 16th, and 17th centuries who believed that mental illness was not a matter of demonic possession or witchcraft; still many still believed that there was some outside phenomenon—such as planetary control—that actually led to mental illness).

21. SURGEON GENERAL REPORT, *supra* note 14, at 75.

22. *Id.*

and later known as mental hospitals.<sup>23</sup> During this period, if individuals suffering mental illness were not cared for at home or in a mental hospital, they would likely be found in jails or other penal institutions.<sup>24</sup> New treatments began to emerge during this time period;<sup>25</sup> however, treatments generally proved largely unsuccessful.<sup>26</sup>

During the 19th and 20th centuries, four separate models were used in an attempt to correct chronic mental illness in members of the general population: the “moral treatment” model, the “mental hygiene” model, the “community mental health” model, and the “community support” model.<sup>27</sup> “Moral treatment,” the first attempt at a broad sociologically based treatment for mental illness, lasted from approximately 1800-1850.<sup>28</sup> The two-pronged treatment goal of “moral treatment” failed, and states regularly built local asylums for chronically ill individuals – funded, however, by local governments.<sup>29</sup> From the late 19th century through World War I, the “mental hygiene” period replaced “moral treatment.”<sup>30</sup> However, the issues of overcrowding and underfunding created atrocious conditions in many mental institutions.<sup>31</sup> The mentally ill – and some suffering illnesses as straightforward as dementia – found themselves mired in a stigmatic game of hot potato, being passed from local to state asylums as local governments found they were unable (or unwilling) to properly care for them.<sup>32</sup>

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23. *Id.*

24. *Id.*

25. *Id.* The Surgeon General Report traces the origin of mental healthcare to the Pennsylvania Hospital, a Philadelphia institution opened in the mid-1700s that had provisions for individuals suffering from mental illness in the basement. *Id.* Also in the mid-1700s, Virginia became the first state to build an asylum for its citizens, and the Williamsburg asylum became the birthplace of specialty mental healthcare. *Id.*

26. SURGEON GENERAL REPORT, *supra* note 14, at 78 (“At best, the hospitals provided humane custodial care; at worst, they neglected or abused the patients.”).

27. See *id.* at 79 tbl. 2-10 (“Moral treatment” lasted from approximately 1800-1850, generally took place in an asylum, and focused on humane, restorative treatment. “Mental hygiene” lasted from about 1890-1920, generally took place in a mental hospital or clinic, and focused on prevention of mental illness and a scientific orientation. “Community mental health” began in 1955 and lasted for about 15 years, generally took place in a community mental health center, and the focus of the reform was on social integration through deinstitutionalization. The “community support” movement has lasted from 1975 through today, generally takes place in the community at large, and the reform focuses on mental illness as a social welfare issue.).

28. *Id.*

29. *Id.* at 78.

30. *Id.* at 79 tbl. 2-10.

31. SURGEON GENERAL REPORT, *supra* note 14, at 78.

32. States were responsible for building public asylums during the 19th and early 20th centuries; however, local governments were required to fund individual cases of care. *Id.*

These conditions eventually led to federal legislation, beginning in the 1950s and continuing through the 1970s, aimed at removing most mentally ill individuals from state-run mental hospitals.<sup>33</sup> World War II ushered in an era of “community mental health centers” that focused on deinstitutionalization and social integration.<sup>34</sup> The end of the Vietnam War brought about the present-day era of “community support” that focuses on mental illness as a social welfare issue.<sup>35</sup> However, community support services are costly and thus widely unavailable to many suffering from mental illness.<sup>36</sup> Furthermore, many of the services necessary to properly run this system have been poorly coordinated and have therefore not benefited those they were designed to assist.<sup>37</sup> While the government’s attempt to correct past wrongs by deinstitutionalizing the mentally ill and integrating them into society was a necessary step in the right direction, the haphazard manner by which deinstitutionalization was achieved has given way to an inferior mental healthcare system, incapable of properly treating the mentally ill.

Historically, society has spurned individuals suffering mental illnesses out of contempt, fear, cruelty, ignorance, and misunderstanding, forcing the individuals to suffer in silence.<sup>38</sup> Their families have also been forced to suffer as their loved ones have been pushed to the “margins of society,” or sometimes worse.<sup>39</sup> As late as 1972, States continued to institutionalize mentally ill citizens and forcibly sterilize them without consent or knowledge of the procedure.<sup>40</sup> A study in the late 1960s showed that the public tended

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Due to inability to properly fund asylums, local governments began to transfer the mentally ill to jails and poorhouses. *Id.* After the public learned of the deplorable conditions at many asylums, state governments passed State Care Acts, which made state governments responsible for the care of their mentally ill population. *Id.* The local governments grabbed this opportunity by the horns and sent every mentally ill asylum resident to the state counterpart facility. *Id.*

33. For example, Congress passed the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282 (appropriating funds for projects aimed at constructing centers for research and assistance of the mentally disabled).

34. SURGEON GENERAL REPORT, *supra* note 14, at 78-79.

35. *Id.* at 79-80.

36. For example, 16% of the United States population does not have health insurance, many people who have health insurance are underinsured for mental disorders, discrimination, a stigma surrounding mental illnesses, and access barriers to members of many racial and ethnic groups. *Id.* All of these reasons prevent people who have mental illnesses from seeking help. *Id.*

37. *Id.* at 101.

38. 141 Cong. Rec. S3001 (daily ed. Jan. 31, 1995) (statement of Sen. Domenici).

39. 141 CONG. REC. S3001-02 (1995).

40. 141 CONG. REC. S3001 (1995).

generally to be repelled by individuals suffering from mental illness, partly because of a public perception that these individuals are dangerous.<sup>41</sup>

These views have not been eradicated in the past thirty to forty years. The ignorance of the biological nature of many mental illnesses continues to have detrimental effects. According to a 1997 survey released by the National Alliance for the Mentally Ill, one in three people with a severe mental illness had been passed over for a job because of their psychiatric label.<sup>42</sup> The outdated and medically inaccurate distinction between mental and physical healthcare continues to advance the stigma of mental illness.<sup>43</sup> The issue of employers turning down potential new hires because of mental illness is far from the only remaining stigma.

In 1996, four years after a mental health parity bill was first introduced on Capitol Hill, the federal government passed the first form of mental health parity legislation applicable on a national level: the MHPA.<sup>44</sup> This Act forced certain health insurance providers to partially cease discrimination against the mentally ill by requiring these plans to create parity in terms of annual and lifetime caps on benefits.<sup>45</sup> The response to the new law, discussed in detail in the following section, proved that discrimination against mental illness was alive and well. While the MHPA banned different annual and lifetime limits between mental health benefits and what the law deemed medical or surgical benefits,<sup>46</sup> it left the door open to essentially all other forms of disparate coverage. The result was that, while most insurance providers had come into compliance with the federal law, eighty-seven percent of these providers now burdened the mentally ill with higher cost-sharing and limitations on access.<sup>47</sup>

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41. HOWARD B. KAPLAN, *THE SOCIOLOGY OF MENTAL ILLNESS* 84 (1972) (citing Jack Elinson et al., *Public Image of Mental Health Services* (1967)).

42. Otto F. Wahl, *Mental Health Consumers' Experience of Stigma*, 25 *Schizophrenia Bull.* 467, 471 (1999).

43. See SURGEON GENERAL REPORT, *supra* note 14, at 7 (discussing recent surveys of public attitudes, finding that while the public has a better understanding of mental illness, people continue to associate mental illness with violent behavior).

44. MHPA, Pub. L. No. 104-204, 110 Stat. 2944 (codified at 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-5).

45. See MHPA § 1185a; see also discussion *infra* Section II.A (discussing the goals, effects, and shortcomings of the MHPA of 1996).

46. See MHPA § 1185a.

47. U.S. GEN. ACCOUNTING OFFICE, *MENTAL HEALTH PARITY ACT: DESPITE NEW FEDERAL STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED* 5 (2000) [hereinafter 2000 GAO REPORT].



## II. MENTAL HEALTH PARITY

A. *The Path to Parity – Goals, Effects, and Failures of the Mental Health Parity Act of 1996*

In an effort to prohibit employers and insurers from discriminating against individuals with respect to access to health care coverage for mental illnesses, Congress enacted the MHPA.<sup>48</sup> The law, which became effective on January 1, 1998, barred employers and insurers from placing lower lifetime or annual dollar limits on mental health benefits than for medical or surgical benefits.<sup>49</sup> The lifetime and annual dollar limits were the only equalities for mental health coverage guaranteed by the MHPA.<sup>50</sup> Based on the lack of additional protections, employers and insurers were permitted implicitly, if not explicitly, to continue restricting coverage of mental illnesses in other financial respects. The narrow scope of the MHPA ensured that although the removal of discriminatory barriers to access for the mentally ill was the stated purpose of the law, its actual effects would prove to be mainly symbolic in nature.<sup>51</sup>

The MHPA, which amended the Employee Retirement Income Security Act (ERISA),<sup>52</sup> the Public Health Services Act (PHSA),<sup>53</sup> and the Internal Revenue Code, was enacted in response to a seemingly concerted effort on the part of insurance providers to lower overall costs by restricting and limiting benefits for mental illnesses in ways not applicable to physical health coverage.<sup>54</sup> Prior to the MHPA's enactment, only about 55 percent of employers in states without comprehensive parity laws reported that they

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48. MHPA, Pub. L. No. 104-204, 110 Stat. 2944 (codified at 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-5); see also C. Geoffrey Weirich & Ashoo K. Sharma, *Tracking the Path to Parity Between Mental and Physical Health Benefits*, 17 LAB. LAW. 469, 470-74 (2002) (discussing the background, requirements, exemptions, and effect of the MHPA).

49. MHPA § 1185a; see also Weirich & Sharma, *supra* note 48, at 471.

50. See Weirich & Sharma, *supra* note 48, at 471 (discussing the MHPA's requirements); see also *id.* at 473 ("[A]n employer's group health plan could continue to impose greater restrictions on the number of covered outpatient office visits or hospital days for mental health treatment than on the number of other health treatments and could require a higher co-pay for such treatment without running afoul of MHPA requirements.").

51. Daniel P. Gitterman et al., *Toward Full Mental Health Parity and Beyond*, HEALTH AFF., July-Aug. 2001, at 68, 68 [hereinafter Gitterman et al., *Full Mental Health Parity*].

52. MHPA § 702 (codified at 29 U.S.C. § 1185a).

53. MHPA § 703 (codified at 42 U.S.C. § 300gg-5).

54. Paul S. Appelbaum, *Litigating Insurance Coverage for Mental Disorders*, 40 HOSP. & COMMUNITY PSYCHIATRY 993, 993 (1989); Brian D. Shannon, *The Brain Gets Sick, Too—The Case for Equal Insurance Coverage for Serious Mental Illness*, 24 ST. MARY'S L.J. 365, 370-75 (1993) (also discussing the reasons for the discrimination). In 1997, Congress also implemented the MHPA by amending the Internal Revenue Code. Taxpayer Relief Act of 1997, Pub. L. 105-34, §§ 1531-32, 111 Stat. 788, 1080-85 (1997).

offered parity in dollar limits between mental health and medical/surgical benefits.<sup>55</sup> The MHPA addressed this issue by requiring group health plans, or coverage provided by an insurer in connection with a group health plan, to “have equal annual and lifetime dollar limits for mental and medical health care benefits.”<sup>56</sup> This parity could be created through one of three methods: 1) an insurer could provide no limits for mental health benefits; 2) an insurer could provide the same limits for both mental and medical health benefits; or 3) an insurer could provide a single limit for both mental and medical health benefits.<sup>57</sup>

With regard to annual and lifetime benefits parity, there is little argument that the law had its intended effect. According to a 2000 Government Accounting Office (GAO) report, 87% of employer insurance plans were in compliance with the MHPA.<sup>58</sup> However, of the employers’ plans that were in compliance with the law, 87% contained at least one plan feature that was more restrictive for mental health benefits than for physical health benefits.<sup>59</sup> Moreover, the GAO report found that employers who implemented parity in dollar limits after enactment of the MHPA were much more likely to have changed another aspect of coverage to be more restrictive on mental health care than were employers who were in compliance prior to the MHPA or who failed to come into compliance.<sup>60</sup> Thus, it seems clear that while the MHPA was enacted to create some level of parity between mental and physical health care coverage, insurers who lacked at least an equivalent level of parity prior to enactment took every measure to ensure that coverage remained equally disparate after enactment.<sup>61</sup>

Clearly the MHPA did not fully address the issues that are responsible for dissimilar coverage. However, the symbolic effect of the law was to create a stepping-stone toward future parity legislation that would perhaps more fully

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55. 2000 GAO REPORT, *supra* note 47, at 11.

56. Michele Garvin et al., *Mental Health Parity: The Massachusetts Experience in Context*, BOSTON BAR J., May-June 2003, at 18, 18.

57. *Id.*

58. 2000 GAO REPORT, *supra* note 47, at 11.

59. *Id.* at 12.

60. See *id.* at 13-14 (Roughly 65% of employers that implemented parity through dollar limits revised one or more aspects of mental health coverage to be more restrictive, while roughly 26% of employers that did not make changes to dollar limits have revised one or more aspects of mental health coverage to be more restrictive.)

61. Insurers created continued disparate coverage by changing certain benefit design features to be more restrictive on mental health care coverage than physical health care coverage. These benefit design changes included: fewer office visits covered; fewer hospital days covered; increased outpatient office visit copayments; increased outpatient office visit coinsurance; increased hospital stay coinsurance; increased hospital stay copayments; and increased caps on enrollee’s out-of-pocket costs. *Id.* at 14 tbl. 5.

benefit those suffering from mental illness. The “strong and unlikely congressional team” of Republican Senator Pete Domenici of New Mexico and Democratic Senator Paul Wellstone of Minnesota authored the MHPA.<sup>62</sup> Both men drew on personal experiences with family members suffering from mental illness to forge a partnership in support of parity legislation.<sup>63</sup> The MHPA was not their first attempt at enacting parity legislation, however. The Senators, along with Representative Marge Roukema, began pursuing federal parity legislation in 1992.<sup>64</sup> The first serious attempt at full parity came in 1996 when Congress considered the Equitable Care for Severe Mental Illness Act of 1995 (ECSMIA),<sup>65</sup> which would have mandated coverage and provided something close to full parity for severe mental illnesses.<sup>66</sup>

The ECSMIA failed to make it out of conference committee.<sup>67</sup> However, Senators Domenici and Wellstone, the National Alliance for the Mentally Ill (NAMI),<sup>68</sup> and the Coalition for Fairness in Mental Illness Coverage

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62. Levinson & Druss, *supra* note 5, at 139.

63. *Id.* Senator Domenici’s daughter was receiving treatment at the time for chronic schizophrenia, and Senator Wellstone’s brother was battling drug addiction and bipolar disorder. *Id.*

64. See Equitable Health Care for Severe Mental Illnesses Act of 1992, S. 2696, 102d Cong. (1992); see also S. REP. NO. 107-61, at 2 (2001); John V. Jacobi, *Parity and Difference: The Value of Parity Legislation for the Seriously Mentally Ill*, 29 AM. J.L. & MED. 185, 192 (2003); Keith Nelson, *Legislative and Judicial Solutions for Mental Health Parity: S. 543, Reasonable Accommodation, and an Individualized Remedy Under Title I of the ADA*, 51 AM. U. L. REV. 91, 102-03 (2001).

65. S. 298, 104th Cong. § 1 (1995).

66. Jacobi, *supra* note 64, at 192. The EHCSMIA defined “severe mental illness” as “an illness that is defined through diagnosis, disability and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.” S. 298 § 6. Notably, the EHCSMIA would have mandated coverage of these illnesses. Specifically, the bill required that “health care coverage, whether provided through public or private health insurance or any other means of financing, must provide for the treatment of severe mental illnesses in a manner that is equitable and commensurate with that provided for other major physical illnesses.” S. 298 § 3(a)(2). A main drawback of the MHPA was that it failed to mandate any coverage of mental illness. See 29 U.S.C. § 1185a(b)(1) (2006) (omitting a mandate directed toward any coverage of mental illness by stating “[n]othing in this section shall be construed . . . as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits . . .”).

67. S. REP. NO. 107-61, at 2; see also Jacobi, *supra* note 64, at 192.

68. NAMI is a grassroots organization founded in 1979 for the purpose of assisting people with mental illnesses and their families; they have affiliates in more than 1,100 communities in the United States. See Nat’l Alliance on Mental Illness, About NAMI: Support, Education, Advocacy, and Research, [www.nami.org/template.cfm?section=About\\_NAMI](http://www.nami.org/template.cfm?section=About_NAMI) (last

(CFMIC)<sup>69</sup> continued to coordinate support for parity legislation.<sup>70</sup> The next step toward mental health parity came in April 1996 when Senators Domenici and Wellstone introduced Amendment 3681 to the Kennedy-Kassebaum health insurance portability measure that would eventually become PL 104-191.<sup>71</sup> Facing opposition from business interest lobbyists and conservative legislators, who were focused on the financial impact parity would have on small businesses and working people and only willing to accept a significantly diminished version of parity, Amendment 3681 initially passed in the Senate but was eventually eliminated, along with every other amendment from the Kennedy-Kassebaum bill.<sup>72</sup>

Following the failure of mental health parity as an amendment to the Kennedy-Kassebaum bill, Domenici and Wellstone continued their aggressive push to enact parity legislation. In August 1996, the Senators introduced a compromised version of their previous mental health parity bill as the MHPA, a freestanding piece of legislation.<sup>73</sup> The bill failed to make it out of the Labor and Human Resources Committee of the Senate.<sup>74</sup> The Senators next attached their proposed parity legislation to a VA/HUD Appropriations bill.<sup>75</sup> Senator Kennedy, who failed to support parity during the debate over his cosponsored insurance portability legislation, showed full support for mental health parity as part of the VA/HUD bill, threatening to filibuster if the proposal was removed from the bill.<sup>76</sup> Senator Kennedy was not, however, the most notable promoter of the proposal. President Clinton also showed his support for parity, sending a letter to Speaker of the House Newt Gingrich "urging the House to quickly enact several important

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visited Sept. 7, 2010). Senator Domenici's wife, Nancy Domenici, was a NAMI board member. Levinson & Druss, *supra* note 5, at 139.

69. The CFMIC is "an aggregation of mental health special interest groups" consisting of mental health professionals, consumers, and health care businesses. Levinson & Druss, *supra* note 5, at 139.

70. *Id.*

71. *Id.* at 140 (discussing how mental health parity eventually passed in the Senate as an amendment to the Kennedy-Kassebaum bill that later became PL 104-191); see Health Insurance Portability and Accountability Act of 1996, Pub. L.No. 104-191, 110 STAT. 1936 (1996); see also Health Insurance Reform Act of 1995, S. 1028, 104th Cong. (1995).

72. Levinson & Druss, *supra* note 5, at 140-41.

73. Mari C. Kjorstad, *The Current and Future State of Mental Health Insurance Parity Legislation*, 27 PSYCHIATRIC REHABILITATION J. 34, 35 (2003).

74. *Id.* Likely the bill never stood a chance as its own piece of legislation. The two instances where it garnered the most support – including the occasion of its passage – came when it was attached to bills that would demand much more debate on the congressional floor: as an amendment to the Health Insurance Reform Act and as an amendment to an appropriations bill.

75. *Id.*

76. Levinson & Druss, *supra* note 5, at 141.

health reform provisions that were passed by the Senate;<sup>77</sup> Clinton was referring to the amendments eliminated from the Kennedy-Kassebaum bill.<sup>78</sup>

Gingrich, along with Republican Senate Majority Leader Trent Lott, agreed to meet with the parity backers, and the two worked with Domenici and Wellstone in order to create an amendment that would be able to pass both houses of Congress.<sup>79</sup> With the support of Senator Kennedy and President Clinton, among others, and the assistance of certain opponents in crafting an agreeable piece of legislation, both Houses of Congress passed mental health parity as an amendment to the VA/HUD bill, and President Clinton signed parity into law on September 26, 1996.<sup>80</sup> While mental health advocates and some lawmakers celebrated the removal of unfair barriers to equal care for mental health services, the compromises required to achieve passage through Congress minimized the effect the MHPA would have on health care coverage.<sup>81</sup>

During the years that followed the passage of the MHPA, it became clear that the effects of the law were "primarily symbolic rather than substantive."<sup>82</sup> The compromises hammered out during the meetings between Domenici, Wellstone, Gingrich, and Lott proved too much for the law to overcome. The exceptions, designed to appease parity opponents, devoured the rule. The failure of true parity from the MHPA can be assigned to the fact that the law fell victim to the same fate as many other pieces of health care legislation, namely, "idealistic access goals bargained away and dismantled by cost-containment concerns,"<sup>83</sup> a trend one commentator has termed "legislative schizophrenia."<sup>84</sup>

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77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.* at 142.

81. See Daniel P. Gitterman et al., *Does the Sunset of Mental Health Parity Really Matter?*, 28 ADMIN. & POL'Y MENTAL HEALTH 353, 355 (2001) [hereinafter Gitterman et al., *Sunset of Mental Health Parity*] (explaining that mental health advocates and law/policy makers thought the unfair barriers to mental health services had been removed by MHPA, which would have been a reason to celebrate; but the conferees were able to minimize the effect of MHPA with several provisions).

82. Gitterman et al., *Full Mental Health Parity*, *supra* note 51, at 68.

83. Maggie D. Gold, *Must Insurers Treat All Illnesses Equally? – Mental vs. Physical Illness: Congressional and Administrative Failure to End Limitations to and Exclusions from Coverage for Mental Illness in Employer-Provided Health Benefits Under the Mental Health Parity Act and the Americans with Disabilities Act*, 4 CONN. INS. L.J. 767, 771 (1998) (citing Christopher Aaron Jones, *Legislative "Subterfuge"?: Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*, 50 VAND. L. REV. 753, 757 (1997)).

84. Jones, *supra* note 83, at 757 n. 23 (citing James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1227, 1227 (1984)).

The exceptions to and exclusions from the MHPA are nearly countless and were noticeable from the outset, essentially rendering the amendments to ERISA and the PHSA meaningless.<sup>85</sup> The supporters of the MHPA cannot be blamed for its failure to create true parity; the opponents simply had too much power in their corner, and thus too many accommodations were required to pass the bill. Business and insurance industry lobbyists<sup>86</sup> as well as fiscal and social conservatives believed that a true parity bill would have a negative impact on their industries and constituents, respectively. Thus, the MHPA represented a substantially watered-down effort toward parity.

First, the concessions lobbied for by Gingrich and Lott, and accepted by Domenici and Wellstone, allowed for one year between enactment and implementation of the bill.<sup>87</sup> This meant that measurement of the potential effects of the MHPA could not begin until January 1, 1998.<sup>88</sup> Furthermore, the law contained a sunset provision at the time of the enactment, which meant the law would only guarantee four years of parity.<sup>89</sup> Business lobbyists were mollified through the addition of “new company” and “small business” exceptions.<sup>90</sup> The small business exception exempted companies who employed 50 or fewer employees during a plan year.<sup>91</sup> Therefore, a group health plan for a company with 50 employees was required to offer no mental health parity whatsoever. Moreover, companies not in existence prior to enactment of the law would be exempt from the requirements of the MHPA if they *predicted* they would fall within the small business exception.<sup>92</sup>

These exceptions arguably were only the tip of the iceberg. The MHPA failed to mandate inclusion of any mental health benefits and, in fact, only applied to insurance plans that already offered mental health benefits.<sup>93</sup> The language of the MHPA is unambiguous: “[n]othing in this section shall be construed as requiring a group health plan (or health insurance

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85. See 2000 GAO REPORT, *supra* note 47, at 5, 7-8 (Exceptions and the narrow scope of MHPA have allowed employers to be in compliance while still making reductions in mental health benefits for employees, which means that the amendments have a limited effect on employees’ access to mental health benefits.).

86. See Judith Havemann, *Businesses Oppose Parity for Mental Health Benefits: Provision in Senate Measure Seen as Too Costly*, WASH. POST, Apr. 26, 1996, at A1 (naming the lobbyists working for the nation’s major employers as the National Association of Manufacturers, the ERISA Industry Committee, the Chamber of Commerce, and the American Association of Private Pension and Welfare Plans).

87. Levinson & Druss, *supra* note 5, at 141.

88. *Id.* at 142.

89. See *id.* (Four years of guaranteed parity from its inception on January 1, 1998 to its sunset on September 30, 2001.).

90. *Id.* at 141.

91. See, e.g., 29 U.S.C. § 1185a(c)(1)(B) (2006).

92. See, e.g., § 1185a(c)(1)(C)(ii).

93. Levinson & Druss, *supra* note 5, at 141-42.

coverage offered in connection with such a plan) to provide any mental health benefits."<sup>94</sup> While the law did apply to insurance plans that offered mental health benefits, nothing in the law precluded these plans from simply discontinuing mental health benefits altogether. Nevertheless, if a company decided to continue offering mental health benefits in conformity with the MHPA, the Act provided another exception in the event the company regretted that decision. If an insurance plan showed a 1% increase in the overall cost of the plan as a result of compliance with the MHPA, the plan would no longer be required to comply with the law.<sup>95</sup> Furthermore, under the MHPA, the insurance plan itself would dictate which conditions would constitute the term mental illness and which treatments would be covered.<sup>96</sup>

More important than what the MHPA explicitly exempted were the aspects of mental health coverage it failed to address. The MHPA did not apply to coverage for treatment for substance abuse or chemical dependency.<sup>97</sup> While the concession to remove coverage for these disorders from the MHPA was likely a personal blow to Senator Wellstone, it was almost certainly a heavier blow to 50% of the mentally ill population who, like Wellstone's brother, also suffer from substance abuse problems.<sup>98</sup> For these individuals the MHPA ensured, at best, a partial correction of the disparate coverage they faced in obtaining health insurance.

The MHPA also failed the mentally ill population by neglecting to fully address the myriad manners in which insurance plans could discriminate against the mentally ill. Under the MHPA, parity only applied to aggregate lifetime and annual coverage limits.<sup>99</sup> If a plan failed to include lifetime

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94. 29 U.S.C. § 1185a(b)(1).

95. See § 1185a(c)(2) ("Increased cost exemption. This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.").

96. See § 1185a(e)(4) ("Mental health benefits. The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.") (emphasis added); see also Jacobi, *supra* note 64, at 192 (discussing that the MHPA is a 'very mild law' because it does not mandate any health coverage).

97. 29 U.S.C. § 1185a(e)(4) ("Mental health benefits. The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.") (emphasis added).

98. Nat'l Alliance on Mental Illness, *Dual Diagnosis: Substance Abuse and Mental Illness* [hereinafter NAMI Dual Diagnosis Report], [www.nami.org/Content/ContentGroups/Helpline1/Dual\\_Diagnosis\\_-\\_Substance\\_Abuse\\_and\\_Mental\\_Illness.htm](http://www.nami.org/Content/ContentGroups/Helpline1/Dual_Diagnosis_-_Substance_Abuse_and_Mental_Illness.htm) (last visited Sept. 11, 2010).

99. Levinson & Druss, *supra* note 5, at 142. "The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar

limits on medical or surgical benefits,<sup>100</sup> it could not impose lifetime limits on mental health benefits.<sup>101</sup> If a plan *did* impose lifetime limits on medical or surgical benefits, the plan could not distinguish between medical or surgical benefits and mental health benefits and could not apply lower limits to mental health benefits.<sup>102</sup> The same restrictions applied to annual limits.<sup>103</sup> Lifetime and annual benefits parity were the only such parity requirements the MHPA created. Not only did the law implicitly allow insurance providers to continue discrimination in other aspects of parity legislation; rather, the language of the MHPA appeared to encourage other forms of discrimination, including higher deductibles, higher copayments, and limits on hospital stays.<sup>104</sup> In this manner, the law utterly failed the

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limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit." 29 U.S.C. §1185a.(e)(1). "The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit." §1185a.(e)(2).

100. See § 1185a(e)(3). The MHPA left the determination of which benefits fell into these categories to the insurance plans. § 1185a(e)(3) ("The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.").

101. 29 U.S.C. § 1185a(a)(1)(A) (2006) ("If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.").

102. § 1185a(a)(1)(B) ("If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either – (i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or (ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.").

103. § 1185a(a)(2)(A) ("If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits."); see also § 1185a.(a)(2)(B) ("If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either – (i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or (ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.").

104. § 1185a(b)(2) ("Nothing in this section shall be construed – in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) of this section (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).").



mentally ill population by not merely creating loopholes for companies and insurance plans to pass through, but by essentially *guiding* these entities through the loopholes.

While proponents of the law lauded its passage,<sup>105</sup> it seemed clear from the language of the MHPA that the loopholes created would limit its effect. This appearance would prove true as the numerous exemptions within the MHPA created a law with extremely narrow scope, thus causing it to have little or no impact on most employees' access to mental health services.<sup>106</sup> This lack of meaningful impact was created by insurance plans that replaced dollar limits on annual and lifetime benefits coverage with equivalent dollar limits on inpatient hospital stays and outpatient office visits, among other restrictions.<sup>107</sup> According to the 2000 General Accounting Office (GAO) report, 87% of plans that were in compliance with the MHPA contained at least one design feature that was more restrictive for mental health benefits than for medical and surgical benefits.<sup>108</sup> Thus, while the efforts of Wellstone and Domenici were admirable, the true impact of the MHPA was negligible.

Likely partially due to the insignificant effect of the law, and partially due to the fact that the MHPA was much weaker than the original law Wellstone and Domenici tried to pass in 1992,<sup>109</sup> the next twelve years saw repeated attempts to correct the errors. In 1997, the year after the MHPA was passed and the year prior to its enactment, Senators Wellstone and Domenici introduced an amendment that would have required State Children's Health Insurance Plans (SCHIPs) to provide full-parity coverage for mental health benefits.<sup>110</sup> The bill never passed the Senate.<sup>111</sup> That same year,

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105. See Press Release, Nat'l Alliance on Mental Illness, *Mental Health Parity Act to Take Effect at Midnight* (Dec. 31, 1997) [hereinafter NAMI Press Release], [www.nami.org/Template.cfm?Section=Press\\_Release\\_Archive&template=/contentmanagement/contentdisplay.cfm&ContentID=5587&title=Mental%20Health%20Parity%20Act%20To%20Take%20Effect%20At%20Midnight](http://www.nami.org/Template.cfm?Section=Press_Release_Archive&template=/contentmanagement/contentdisplay.cfm&ContentID=5587&title=Mental%20Health%20Parity%20Act%20To%20Take%20Effect%20At%20Midnight) (quoting NAMI Executive Director Laurie Flynn as saying, "The days of [mental health patients] being cast as second-class citizens from a health care system historically indifferent to their needs are over.").

106. Gitterman et al., *Sunset of Mental Health Parity*, *supra* note 81, at 356.

107. *Id.* See also 2000 GAO REPORT, *supra* note 47, at 5.

108. Gitterman et al., *Sunset of Mental Health Parity*, *supra* note 81, at 356 (citing 2000 GAO REPORT, *supra* note 47, at 5).

109. The Equitable Health Care for Severe Mental Illnesses Act of 1992, S. 2696, 102d Cong. (1992). Aimed at creating nondiscriminatory legislation, the bill, introduced by Senators Domenici and Danforth, applied to severe mental illnesses and mandated mental healthcare coverage that would not be "more restrictive than coverage provided for other major physical illnesses." S. 2696.

110. RAMYA SUNDARARAMAN & C. STEPHEN REDHEAD, CRS REPORT FOR CONGRESS: THE MENTAL HEALTH PARITY ACT: A LEGISLATIVE HISTORY 6 (2007) [hereinafter CRS REPORT], available at [edlabor.house.gov/testimony/071007MentalHealthParityCRSReport.pdf](http://edlabor.house.gov/testimony/071007MentalHealthParityCRSReport.pdf).

Representative Pete Stark introduced the National Mental Health Parity Act of 1997 on the floor of the House.<sup>112</sup> The language of that bill was the same as a bill Rep. Stark entered during the previous legislative session, and it would have required group health plans to cover all mental illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).<sup>113</sup> On March 26, 1998, an Act entitled the Mental Health and Substance Abuse Parity Amendments of 1998 was introduced.<sup>114</sup> This bill would have amended the MHPA to require full parity for both mental health and substance abuse,<sup>115</sup> but it would not have mandated coverage.<sup>116</sup>

The 106th Congress saw the introduction of four more mental health parity bills, none of which was taken up by either House.<sup>117</sup> In 1999, however, President Clinton issued Executive Order 13,124 directing the Office of Personnel Management (OPM) to implement full parity for mental health benefits in all plans offered by the Federal Employees Health Benefits Program.<sup>118</sup> This Order required all FEHBP plans to cover medically necessary treatments for all mental illnesses listed in the DSM-IV.<sup>119</sup> Two years later, with the MHPA preparing to sunset, Senators Domenici and Wellstone introduced the Mental Health Equitable Treatment Act of 2001

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111. *Id.*

112. H.R. 621, 105th Cong. § 9901 (1997).

113. H.R. 4045, 104th Cong. § 9901 (1996).

114. H.R. 3568, 105th Cong. (1998).

115. H.R. 3568 (stating that the purpose of the amendment was “to prohibit group and individual health plans from imposing treatment limitations or financial requirements on the coverage of mental health benefits and on the coverage of substance abuse and chemical dependency benefits if similar limitations or requirements are not imposed on medical and surgical benefits”); CRS REPORT, *supra* note 110, at 6.

116. CRS REPORT, *supra* note 110, at 6 (stating that full parity coverage is only required for plans that offer mental health and substance abuse coverage).

117. *Id.* at 7. See also Mental Health Equitable Treatment Act of 1999, S. 796, 106th Cong. § 2 (1999) (amending the MHPA to require parity in inpatient days and outpatient visits, as well as full parity for severe biological mental illnesses); Mental Health and Substance Abuse Parity Amendments of 1999, H.R. 1515, 106th Cong. § 2(a) (1999) (amending Employee Retirement Income Security Act of 1974 (ERISA), 28 U.S.C. § 1185(a), to require full parity for mental health benefits); Mental Health Parity Enhancement Act of 1999, H.R. 2445, 106th Cong. § 2 (1999) (amending ERISA, Public Health Service Act, and Internal Revenue Code of 1986 to require parity for treatment limitations); National Mental Health Parity Act of 1999, H.R. 2593, 106th Cong. § 9901 (1999) (using language originally introduced by Rep. Stark in previous Acts).

118. See Exec. Order No. 13,124, 3 C.F.R. 192 (2000), *reprinted in* 5 U.S.C. § 3301 (2000); see also Remarks at the White House Conference on Mental Health, 1 PUB. PAPERS 896 (June 7, 1999) (President Clinton ensured that all federal employees would receive full mental health benefits.).

119. CRS REPORT, *supra* note 110, at 7.

which would require full parity for all DSM-IV diagnoses.<sup>120</sup> Importantly, while the Congressional Budget Office predicted a four percent increase in overall healthcare premiums as a result of the MHPA,<sup>121</sup> the CBO predicted only a 0.9% increase as a result of this new legislation.<sup>122</sup> Even so, the House rejected the Senate bill, and instead voted to reauthorize the MHPA for another year.<sup>123</sup> In 2002, another parity bill was introduced in the House,<sup>124</sup> but the only further action taken was the reauthorization of the MHPA through the end of 2003.<sup>125</sup>

The next Congress further extended the MHPA through the end of 2005.<sup>126</sup> Three additional bills were introduced but went nowhere.<sup>127</sup> The 109th Congress played the same part, with the House failing to pass the Paul Wellstone Mental Health Equitable Treatment Act of 2005,<sup>128</sup> the Senate failing to introduce any legislation, and two House bills extending the MHPA provisions through 2007.<sup>129</sup> While every Congress from the 102nd through the 110th introduced mental health parity legislation, almost always in each House, only two were successful in becoming law. The 104th Congress passed the MHPA,<sup>130</sup> and in 2008, the 110th Congress passed the MHPAEA near the end of its legislative session.<sup>131</sup>

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120. S. 543, 107th Cong. § 2(f)(3) (2001).

121. CONG. BUDGET OFFICE, CBO'S ESTIMATES OF THE IMPACT ON EMPLOYERS OF THE MENTAL HEALTH PARITY AMENDMENT IN H.R. 3101 1 (1996) [hereinafter H.R. 3103 COST ESTIMATE], available at <http://www.gov/publications/bysubject.cfm?cat=9>.

122. CONG. BUDGET OFFICE, COST ESTIMATE: S. 543: MENTAL HEALTH EQUITABLE TREATMENT ACT OF 2001 3 (2001) [hereinafter S. 543 COST ESTIMATE], available at <http://www.cbo.gov/ftpdocs/30xx/doc3013/s543.pdf>.

123. CRS REPORT, *supra* note 110, at 8.

124. Mental Health Equitable Treatment Act of 2002, H.R. 4066, 107th Cong. (2002).

125. CRS REPORT, *supra* note 110, at 8.

126. See Mental Health Parity Reauthorization Act of 2003, S. 1929, 108th Cong. § 2 (2003) (continuing the MHPA provisions of ERISA and PHSa through 2004); Working Families Tax Relief Act of 2004, H.R. 1308, 108th Cong. § 302 (2004) (continuing the MHPA provisions of ERISA and PHSa through 2005).

127. Senator Daschle introduced S. 10, Health Care Coverage Expansion and Quality Improvement Act of 2003, Representatives Kennedy and Ramstad and Senators Domenici and Kennedy introduced H.R. 953/S. 486, Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, in February 2003, and Senator Daschle introduced S. 1832, Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, in November 2003. CRS REPORT, *supra* note 110, at 9-10.

128. H.R. 1402, 109th Cong. (2005).

129. CRS REPORT, *supra* note 110, at 10.

130. RAMYA SUNDARARAMAN, CRS REPORT FOR CONGRESS: MENTAL HEALTH PARITY: AN OVERVIEW 4 (2008).

131. CONG. RESEARCH SERV., CRS REPORT FOR CONGRESS, MENTAL HEALTH PARITY: AN OVERVIEW, 4 (2008) ("[K]ey negotiators in the Senate used H.R. 1424, the original mental health parity legislation passed in the House in the 110th Congress, as the vehicle to pass the

The reasons for the lack of meaningful impact from the MHPA seem obvious: the exceptions to parity swallowed the rule of parity. The reason for the failure of any new legislation to be passed during the twelve years after enactment of this law seems less obvious. While numerous exceptions were created to dampen the MHPA's parity impact, it appears that one key rationale existed for the creation of its exemptions and for subsequent legislative failures. As mentioned, aside from the business and insurance lobbyists, fiscal conservatives supplied much of the opposition to mental health parity legislation. The interests of these groups seem patently aligned. Businesses and insurance companies, for obvious reasons, seek to keep costs at a minimum, and fiscal conservatives, as their moniker suggests, are concerned with the overall costs of government. Thus, the uncertain price tag of true mental health parity has remained a constant barrier to parity legislation.

The following section will address the issue of cost with regard to the passage of parity legislation, both how cost concerns affected the language of the MHPA and how these concerns helped create a twelve year gap between passage of the MHPA and its predecessor, the MHPAEA. It will also address the two main cost counterarguments presented by parity proponents and the irony that stems from the opposition's cost argument; namely that, while opponents of parity legislation decry its potential for increasing health care coverage costs, proponents of parity point to evidence that health care costs are already dramatically higher due to the lack of parity in coverage of mental illness.

#### B. *The Cost of Parity – Is There Another Side to the Coin?*

Throughout the nearly two decades parity legislation has been considered on Capitol Hill and in state legislatures, the cost of true parity in insurance coverage has been the most debated concern. The prohibitive cost argument has always been the driving force behind efforts of business and insurance lobbyists to prevent passage of any parity legislation, eventually resulting in the diluted legislation that was the MHPA.<sup>132</sup> And

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compromised mental health parity legislation within the Emergency Economic Stabilization Act of 2008).

132. See, e.g., *Small Business Backs Health Care Compromise*, U.S. NEWSWIRE, June 19, 1996. The National Federation of Independent Business (NFIB) supported a health care reform compromise, but did not support any form of mental health parity mandate. *Id.* The health care compromise that the NFIB backed was the Kennedy-Kassabaum measure discussed *supra* at Section II.A. *Id.* Using strong language to show the organization's stance on mental health parity, NFIB President Jack Faris said, "Any form of the mental health provision is a poison pill to the health care compromise . . . Mandating costly mental health benefits defeats the very purpose of health care reform which is to lower health care costs and to insure more people." *Id.*

while the MHPAEA is certainly a much more extensive step toward true parity, cost was likely still the main issue that kept the new Act from achieving its full potential. Business and insurance lobbyists do not argue against parity mandates solely because of the debatable effect on premium costs. Rather, these entities also resist mental health parity because mental health services, they argue, are imprecise; and “diagnosis, prognosis, and treatment decisions seemed to rely on disparate and untested understandings of the nature of mental illness.”<sup>133</sup>

Fear of cost increases for insurance companies, employers, and employees is a justifiable concern, especially considering the current global economic conditions;<sup>134</sup> nevertheless, supporters raise at least two cost arguments of their own, and these arguments appear to be downplayed by the opposition. The first cost argument of parity proponents began while trying to enact the original parity legislation that eventually became the MHPA. That argument was that the opposition’s prediction for cost increases were dramatically inflated, and actual cost increases would be much lower than opponents predicted.<sup>135</sup> While that argument essentially remains today, it has become much more pointed. Researchers on the subject have stated the current pro-parity cost argument succinctly: “[o]pposition to parity on the basis of increased total spending no longer constitutes an evidence-based objection.”<sup>136</sup> Put more directly, the first argument now is that those who maintain a cost-based stance against parity are simply incorrect. The second cost argument that supporters advance is that failing to treat mental illness actually creates substantial direct and indirect societal costs that outweigh any potential increase in cost resulting from expansion of mental health treatment.<sup>137</sup>

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133. Jacobi, *supra* note 64, at 193. See also, *supra* Section I for discussion of why this argument is likely unsupportable.

134. See Emergency Economic Stabilization Act of 2008, H.R. 1424, 110th Cong. §§ 511, 512 (2008) (including the MHPAEA as a special tax provision of the Emergency Economic Stabilization Act of 2008).

135. See CONG. BUDGET OFFICE, COST ESTIMATE: H.R. 1424: PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007 7 (2007), available at [http://www.cbo.gov/ftp\\_docs/88xx/doc8837/hr1424ec.pdf](http://www.cbo.gov/ftp_docs/88xx/doc8837/hr1424ec.pdf) (predicting full benefits parity would increase employer-based health insurance premiums by only 0.4%). But see Dana L. Kaplan, *Can Legislation Alone Solve America’s Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J. 325, 337 (2005) (citing a 2003 report from the Commerce & Industry Association of New Jersey that predicted mandated mental health coverage would create a 20% increase in costs).

136. See Colleen L. Barry et al., *The Costs of Mental Health Parity: Still an Impediment?*, 25 HEALTH AFF. 623, 632 (2006).

137. See SURGEON GENERAL REPORT, *supra* note 14, at 411-13. “In 1996 the United States spent more than \$99 billion for the direct treatment of mental disorders, as well as substance abuse, and Alzheimer’s disease and other dementias . . . . More than two-thirds of

Which interest group one speaks to will determine the answer to whether full parity is affordable.<sup>138</sup> Opponents to mandated mental health parity include trade organizations, businesses, and insurance associations.<sup>139</sup> These groups cite certain studies and reports to support their contention that parity will result in extreme increases in insurance costs;<sup>140</sup> they argue that mandated parity in insurance coverage is simply too costly to be a viable option. Aside from the obvious reasons why cost increases are disliked by policyholders, opponents to parity legislation argue that any cost increase in the voluntary health insurance market results in a subsequent decrease in coverage.<sup>141</sup> In this way, parity opponents appear to be making an altruistic argument. By maintaining disparate coverage levels, insurance companies are actually allowing more individuals to be insured. As laudable as this argument appears, it is only supportable if increasing parity actually increases costs.

Opposing mental health parity because of potentially devastating cost increases likely was a more credible argument when the MHPA was passed in 1996 than it is today. This is largely due to the advent of managed care and its ever-increasing role in the insurance industry. The cost of mental health insurance has been defined by two eras of economic research.<sup>142</sup> The first era includes research from the 1970s through the 1980s, and the second era comprises research from the mid-1990s forward.<sup>143</sup> Historically—that is, during the first era of research—the purpose of such studies was to determine the effect of prices on the demand for mental healthcare.<sup>144</sup> Researchers sought to determine whether lower prices of care, as a result of increased coverage of certain mental illnesses and corresponding treatments, would increase overall demand for such care and

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this amount (\$69 billion or more than 7 percent of total health spending) was for mental health services.” *Id.* at 412.

138. See Kaplan, *supra* note 135, at 333-42.

139. *Id.* at 337.

140. *Id.*

141. See CONG. BUDGET OFFICE, CBO’S ESTIMATES OF THE IMPACT ON EMPLOYERS OF THE MENTAL HEALTH PARITY AMENDMENT IN H.R. 3103 4 (1996), available at <http://www.cbo.gov/doc.cfm?index=10603> (estimating that the parity requirement could result in 400,000 fewer workers having employment based coverage).

142. See Barry et al., *supra* note 136, at 625.

143. *Id.* (noting that the first era, during the 1970s and 1980s, encompasses research prior to the managed care era, and the second era, from the mid-1990s to present day, essentially is the managed care era).

144. *Id.*

treatment.<sup>145</sup> More recently, however, research has focused on “natural experiments” to determine the effect of managed care on parity coverage.<sup>146</sup>

The opposition to mental health parity has long stemmed from insurers’ fear that full coverage of mental healthcare and treatment would drive up premium costs.<sup>147</sup> The fear of higher premium costs led to exclusions and limitations in coverage of mental illnesses, beginning when insurance providers first offered mental health coverage.<sup>148</sup> These exclusions and limitations were accepted, especially early on, because state governments remained largely responsible for the mental health system.<sup>149</sup> Insurers’ concerns regarding the potential for increases in costs and resulting higher premiums were buttressed by a series of studies throughout the 1980s on price elasticity of demand for mental healthcare.<sup>150</sup> Five sets of study results published between 1981 and 1989 all showed substantially higher price elasticity for mental health services than for general health services.<sup>151</sup> This meant that as the price to the consumer of mental healthcare services increased, the demand for such services correspondingly decreased at a greater rate than the demand for general healthcare services.<sup>152</sup>

These results created the justification that insurance providers needed to dramatically increase discrimination against mental healthcare services ostensibly as a cost containment measure. In 1981, when the first of the price elasticity studies was reported, forty-one percent of full-time employee

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145. *Id.* at 625-626.

146. *Id.* at 625 (defining “natural experiments” as the means by which current researchers obtain their data; specifically, some current studies are carried out by comparing individuals residing in states with comprehensive parity statutes with individuals in states without such statutes).

147. Barry et al., *supra* note 136, at 625 (finding that the resistance to equal coverage has existed since the 1950s when major medical contracts first began offering mental health coverage in any form).

148. *Id.*

149. Richard G. Frank et al., *Will Parity in Coverage Result in Better Mental Health Care?*, 345 N. ENG. J. MED. 1701, 1701 (noting that in 1956, the state-based public mental health system accounted for about eighty-five percent of mental health expenditures).

150. See Barry et al., *supra* note 136, at 626-27. Barry reviewed five studies comparing the price elasticity of demand for mental healthcare against the price elasticity of demand for general healthcare. *Id.* The price elasticity of demand describes the percentage change in quantity of products or services demanded by consumers—in this case, mental health or general health services—relative to the change in price of those products or services.

151. *Id.*

152. See Gold, *supra* note 83, at 773-77 (discussing the arguments of opponents and advocates of parity with regard to “moral hazard” – a consumer behavior related cost theory related to the price elasticity of demand, which says that demand will increase as plan generosity increases and discussing “adverse selection” – the fear that if some plans offer more mental health benefits, those plans will attract a greater proportion of higher cost populations, resulting in a decrease in coverage or increase in premium costs).

participants in plans with mental health benefits were subject to separate limitations on hospital care, and eighty-three percent of these plan participants were subject to separate limitations on outpatient care.<sup>153</sup> By 1995, the year prior to enactment of the MHPA, eighty-one percent of full-time employees in medium and large private establishments were subject to separate limitations on coverage for inpatient care, and ninety-six percent of these employees faced separate limitations on coverage for outpatient care.<sup>154</sup>

Insurance providers have not used only the price elasticity studies to foster their argument against parity. Countless studies were conducted in the past fifteen years to determine the percentage increase in total health plan expenses that would result from mental health parity. Many of these studies resulted in statistics that appeared to support the position of business and insurance industry lobbyists, especially in the early to mid-1990s. However, many of these studies resulted in statistics that support parity. In fact, as time passes, the general argument that parity will increase overall health plan expenses becomes less and less viable.

In preparation for debates prior to passage of the MHPA, the Association of Private Pension and Welfare Plans (APPWP), however, concluded that direct health plan expenses would increase with the expansion of mental health care coverage.<sup>155</sup> It suggested that parity in coverage of serious mental illnesses alone would result in an eight to eleven percent increase in total health plan expenses.<sup>156</sup> Four additional actuarial studies in 1996 further confused the cost debate by widening the range of the estimated increase in health insurance premiums to be expected from the MHPA. A Coopers and Lybrand study predicted a 3.2 percent increase;<sup>157</sup> Milliman and Robertson, Inc., estimated a 3.9 percent increase;<sup>158</sup> the Congressional Budget Office predicted a 4 percent increase;<sup>159</sup> and, Price Waterhouse estimated an 8.7 percent increase.<sup>160</sup>

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153. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, EMPLOYEE BENEFITS IN MEDIUM AND LARGE FIRMS, 1981 1, 27 tbl. 26 (1982) (reporting statistics for full-time employees in medium and large establishments depending on the industry).

154. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, EMPLOYEE BENEFITS IN MEDIUM AND LARGE PRIVATE ESTABLISHMENTS, 1995 71 tbl. 75 (1998).

155. Watson Wyatt Worldwide, Ass'n of Private Pension & Welfare Plans, Action Ctr. for Quality Health Care, *The Costs of Uniform Plan Provisions for Medical and Mental Health Services: An Analysis of S. 298, the "Equitable Health Care for Severe Mental Illness Act"* 1 (1996) (unpublished study) (on file with author).

156. *Id.*

157. Merrile Sing and Steven C. Hill, *The Costs of Parity Mandates for Mental Health and Substance Abuse Insurance Benefits*, 52 PSYCHIATRIC SERVICES 437, 437 (2001).

158. *Id.*

159. H.R. 3103 COST ESTIMATE, *supra* note 122, at 1.



These massive differences in cost projections—from less than four percent to eleven percent—resulted in the addition of the cost increase safety provision of the MHPA; if a covered entity experienced a premium increase of more than one percent as a result of parity costs, it would not be required to comply with the Act.<sup>161</sup>

This numbers game has continued throughout the period between passage of the MHPA and the MHPAEA. According to a 2002 study by PricewaterhouseCoopers for the American Association of Health Plans, health insurance premiums for large employers increased by 13.7% between 2001 and 2002.<sup>162</sup> This large increase in overall health insurance premiums has spurred the belief that increased access to health care coverage—mental health care in particular—will result in employers reducing overall benefits offered, shifting costs to employees, or canceling healthcare coverage entirely.<sup>163</sup>

Proponents of mental health parity rely on substantial research that shows the true cost of parity is much less than even the lowest predictions advanced in preparation for the MHPA debates. In June 2000, the National Advisory Mental Health Council's Report to Congress projected a 1.4 percent increase as a result of full parity for mental health benefits.<sup>164</sup> However, it is likely that even this projection was inflated as it was still based on actuarial and economic forecasting models, rather than actual numbers presented as a result of the publication of State and large-employer parity experiences.<sup>165</sup> A little over a year later, in August 2001, the Congressional Budget Office (CBO), which in 1996 predicted a four percent increase in health insurance premiums as a result of the MHPA, released its Cost Estimate<sup>166</sup> for the Mental Health Equitable Treatment Act of 2001

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160. Ronald E. Bachman, Pricewaterhouse Coopers, *An Actuarial Analysis of S. 543: Mental Health Equitable Treatment Act of 2001* 18 (unpublished manuscript) (on file with author).

161. 29 U.S.C. § 1185a(c)(2) (2000).

162. PRICEWATERHOUSECOOPERS, *THE FACTORS FUELING RISING HEALTHCARE COSTS: 2008 4* (2008), available at <http://www.ahip.org/content/default.aspx?docid=25123> (finding, however, that the increase was less dramatic between 2004 and 2005, at only 8.8%).

163. Merrile Sing & Steven C. Hill, *The Costs of Parity Mandates for Mental Health and Substance Abuse Insurance Benefits*, 52 *PSYCHIATRIC SERVICES* 437, 440 (2001).

164. RUTH L. KIRSCHSTEIN, DEP'T HEALTH & HUMAN SERVS., *INSURANCE PARITY FOR MENTAL HEALTH: COST, ACCESS, AND QUALITY: FINAL REPORT TO CONGRESS BY THE NATIONAL ADVISORY MENTAL HEALTH COUNCIL* 3, 32, 33 (2000) [hereinafter *NAMHC REPORT*], available at <http://www.nimh.nih.gov/about/advisory-boards-and-groups/namhc/reports/nimh-parity.pdf>.

165. See *id.* at 10; Kevin D. Hennessy & Howard H. Goldman, *Full Parity: Steps Toward Treatment Equity for Mental and Addictive Disorders*, *HEALTH AFF.*, July-Aug. 2001, at 58, 62.

166. S. 543 *COST ESTIMATE*, *supra* note 122, at 1.

(MHETA).<sup>167</sup> The CBO estimated that the MHETA would increase group health insurance premiums by an average of 0.9%.<sup>168</sup> That same month, the American Psychological Association retained PricewaterhouseCoopers to analyze the potential added cost for coverage under the MHETA.<sup>169</sup> According to its analysis, PricewaterhouseCoopers determined that mental health coverage on par with physical health coverage would increase employers' costs by one percent, or \$1.32 per employee per month.<sup>170</sup> When the CBO released its Cost Estimates for the 2007 versions of mental health parity legislation,<sup>171</sup> it had decreased the predicted increase in health care premiums to 0.4%.<sup>172</sup>

While even some *supporters* of parity state that it is "undeniable" that parity for the treatment of mental illness will raise insurance costs,<sup>173</sup> this sentiment is no longer held by many on the advocates' side of the debate. Managed behavioral health companies (MBHCs) have had a substantial effect on the actual costs of current mental health and the predicted costs of mental health parity.<sup>174</sup> By 1999, 177 million Americans' mental health

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167. S. 543, 107th Cong. (2001) (One of the most comprehensive proposals this Act contained mandated full parity for all mental illnesses covered under the Diagnostic & Statistics Manual for Mental Disorders, Fourth Edition (DSM-IV)).

168. S. 543 COST ESTIMATE, *supra* note 122, at 3.

169. Mathew G. Simon, *Not All Illnesses Are Treated Equally—Does a Disability Benefits Plan Violate the ADA by Providing Less Generous Long-Term Benefits for Mentally Disabled Employees than for Physically Disabled Employees?*, 8 U. PA. J. LABOR & EMP. L. 943, 975 (2006).

170. Bachman, *supra* note 160, at 6.

171. See SUNDARAMAN, *supra* note 130, at 3-4 (discussing that the Mental Health Parity Act of 2007 (S. 558) and the Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424) were both predecessors of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008).

172. CONG. BUDGET OFFICE, CONGRESSIONAL BUDGET OFFICE COST ESTIMATE: H.R. 1424: PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007 4 (2007), available at <http://www.cbo.gov/ftpdocs/88xx/doc8837/hr1424ec.pdf>.

173. See, e.g., Simon, *supra* note 169, at 975 ("It is undeniable that parity . . . will cost insurers more."); see also Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63, 92 (1997) ("It is undeniable that the inclusion of expanded coverage for the treatment of mental illness . . . will cost money.").

174. See Barry, *supra* note 136, at 632 ("[P]arity implemented in the context of managed care would have little impact on mental health spending and would increase risk protection."); M. Audrey Burnam & José J. Escarce, *Equity in Managed Care for Mental Disorders: Benefit Parity Is Not Sufficient to Ensure Equity*, HEALTH AFF., Sept.-Oct. 1999, at 22, 26 (explaining how costs of mental health care rise only a small amount under managed care plans); Jacobi, *supra* note 64, at 194 (attributing the reduction in price of mental health parity to adoption of MBHC methods); Samuel H. Zuvekas et al., *The Impacts of Mental Health Parity and Managed Care in One Large Employer Group*, HEALTH AFF., May-June, 2002, at 148, 152,

services were covered by MBHCs, and these companies covered nearly eighty percent of all privately insured persons.<sup>175</sup> This substantial coverage has resulted in an equally substantial effect on costs.<sup>176</sup> According to a 2001 Report to the Substance Abuse and Mental Health Services Administration, large organizations that already used MBHCs saw minimal cost increases as a result of parity implementation, and those that switched to MBHCs during parity implementation experienced thirty to fifty percent reductions in total mental health costs.<sup>177</sup> The fear, however, is that while helping end the cost debate, managed care may threaten the fundamental goal of parity: the creation of true equity between mental and physical illness in access to care.<sup>178</sup> The arguments for and against managed care in general, and with regard to mental healthcare specifically, are too detailed to discuss here. However, it is arguably valid to suggest that before full attention is turned to the issues of the managed care system with regard to mental health equity, mandated coverage of mental illness and true parity in benefit design should be fully addressed. While the MHPAEA has been praised for creating full parity, the legislation retains certain loopholes, thus risking continued discrimination in benefit design itself.<sup>179</sup>

Today there is little question that parity can be affordable. Several states have demonstrated just this and, in some instances, have also shown that access to mental healthcare has increased through parity. A 2003 study showed that Vermont's sweeping mental health and substance abuse parity law, implemented in 1998, resulted in an eight to eighteen percent

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154 (finding that mental health costs dropped under managed care, while treatment prevalence and out-patient use increased).

175. Steven Findlay, *Managed Behavioral Health Care in 1999: An Industry at a Crossroads*, HEALTH AFF., Sept.-Oct. 1999, at 116, 116.

176. See Jacobi, *supra* note 64, at 194 (citing Findlay, *supra* note 175, at 117).

177. See KRISTEN REASONER APGAR, WASH. BUS. GRP. ON HEALTH, LARGE EMPLOYER PRACTICES IN BEHAVIORAL HEALTH BENEFIT DESIGN, SUBSTANCE ABUSE BENEFITS, AND THE USE OF CARVE-OUTS—THE IMPLICATIONS FOR PARITY 6 (2001), available at [http://www.businessgrouphealth.org/pdfs/final\\_report.pdf](http://www.businessgrouphealth.org/pdfs/final_report.pdf) (citing MERRILE SING ET AL., U.S. DEP'T HEALTH & HUMAN SERVS., INSURANCE BENEFITS: THE COSTS AND EFFECTS OF PARITY FOR MENTAL HEALTH AND SUBSTANCE ABUSE INSURANCE BENEFITS 14 (1998); William Goldman et al., *Costs and Use of Mental Health Services Before and After Managed Care*, HEALTH AFF., Mar.-Apr. 1998, at 40, 40).

178. See Jacobi, *supra* note 64, at 196; see also Burnam, *supra* note 174, at 27 (discussing the shift from the "demand-side cost containment strategies" of benefit design features in fee-for-service plans to the "supply-side cost-control strategies" of managed care, where utilization management and medical necessity definitions determine who receives benefits); Roland Sturm & Rosalie Liccardo Pacula, *State Mental Health Parity Laws: Cause or Consequence of Differences in Use?*, HEALTH AFF., Sept.-Oct. 1999, at 182, 191 (discussing the persistence of lower utilization of mental health services even after state parity laws are passed, and suggesting that parity legislation has not created a statistically significant increase in mental health and substance abuse disorder utilization).

179. See *infra* Part IV for discussion on MHPAEA's positive and negative attributes.

decrease in mental health and substance abuse spending and an eighteen to twenty-four percent increase in access to mental health care.<sup>180</sup> Maryland began the transition to parity for mental illness and substance abuse disorders in 1994, with a managed care system already in place.<sup>181</sup> During the year of transition to parity, the cost for treatment of mental and addictive disorders rose by 0.84% of overall benefit costs; during the second year of parity, costs for these treatments remained level; and, in the third year of parity, costs for such treatments fell by 0.27%.<sup>182</sup> In implementing its mental health parity statute for state employees only, Texas saw more than a fifty percent reduction in mental health care costs over the first five years of parity, a significant enough decrease for the state to introduce legislation creating parity for all residents.<sup>183</sup> Other states have seen similar outcomes as a result of mental health and substance abuse disorder parity implementation.<sup>184</sup>

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180. U.S. DEP'T HEALTH & HUMAN SERVS., EFFECTS OF THE VERMONT MENTAL HEALTH AND SUBSTANCE ABUSE PARITY LAW 57-58 (2003) [hereinafter VERMONT PARITY STUDY], available at <http://www.mathematica-mpr.com/PDFs/vtparity.pdf>.

181. See HAROLD E. VARMUS, U.S. DEP'T HEALTH & HUMAN SERVS., PARITY IN FINANCING MENTAL HEALTH SERVICES: MANAGED CARE EFFECTS ON COST, ACCESS AND QUALITY: AN INTERIM REPORT TO CONGRESS BY THE NATIONAL ADVISORY MENTAL HEALTH COUNCIL 10 (1998), available at <http://www.nimh.nih.gov/about/advisory-boards-and-groups/namhc/reports/nimh-parity-report.pdf>.

182. *Id.* at 11.

183. *Id.* at 10 (discussing the Texas program and the effect of a new managed care system on the cost of parity).

184. See generally Roland Sturm et al., *Mental Health and Substance Abuse Parity: A Case Study of Ohio's State Employee Program*, 1 J. MENTAL HEALTH POL'Y & ECON., 129, 129 (1998). In Ohio, a state employee parity program was instituted in 1991 and expanded in 1993 and 1997. *Id.* at 131-32 tbl. 3. A study of that state's parity program showed that mental health and substance abuse disorder costs fell following full implementation in the two years of expansion. *Id.* at 132. Ten years after implementation, there was "no evidence of a cost explosion"; in fact, mental health and substance abuse costs had remained level. ROLAND STURM, RAND: THE COSTS OF COVERING MENTAL HEALTH AND SUBSTANCE ABUSE CARE AT THE SAME LEVEL AS MEDICAL CARE IN PRIVATE INSURANCE PLANS 3 (2001), available at <http://www.rand.org/pubs/testimonies/2005/CT180.pdf>. A study of California's parity implementation showed similar outcomes. See Ronald Branstrom & Roland Sturm, *An Early Case Study of the Effects of California's Mental Health Parity Legislation*, 53 PSYCHIATRIC SERVICES 1215, 1215 (2002). The 2001 study reviewed the effect of parity on two large employer groups, one with higher than average utilization rates before and after parity (Employer A), and one with lower utilization rates prior to parity but seeing a substantial increase in utilization post-parity (Employer B). *Id.* at 1215-16. Employer A witnessed both a decline in mental healthcare spending (-1.9%) and large reductions in outpatient, intermediate-care, and inpatient service utilization. *Id.* at 1216. Employer B, while experiencing substantial increases in utilization and spending, saw an overall mental healthcare spending increase of less than one percent of total healthcare spending, an amount equal to \$12 per member, per year. *Id.*

However, direct healthcare expenditures are not the only costs that parity advocates suggest support their argument. Rather, proponents argue that the failure to treat mental illness adequately creates substantial direct and indirect costs to society that outweigh any potential increase in cost caused by implementing parity.<sup>185</sup> When the 1999 Surgeon General's Report on mental health was issued, it found that mental illness was the second-greatest burden of disease in countries with established market economies.<sup>186</sup> The burden of disease classification was measured by what the World Health Organization ("WHO") termed "disability-adjusted life years," essentially the number of years of life lost due to poor health or premature death.<sup>187</sup>

In 2004, the WHO updated their burden of disease study and the statistics had changed.<sup>188</sup> Globally, unipolar depressive disorder is now the third leading cause of burden of disease.<sup>189</sup> In middle- and high-income countries, this disorder is the number one cause of burden of disease.<sup>190</sup> Similarly disheartening, alcohol use disorders are the eighth and fifth leading cause of disease burden in middle- and high-income countries respectively.<sup>191</sup> The WHO study shows that globally, and especially in upper-income countries, a highly treatable mental disorder and an off-related substance abuse disorder constitute two of the leading causes of years of life lost to premature death and less than full health.<sup>192</sup>

According to the Surgeon General Report, the direct cost of treating mental illness was \$69 billion in 1996, the year the MHPA was enacted.<sup>193</sup> In the twelve years since passage of the MHPA, medical inflation has

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185. See Kennedy, *supra* note 12, at 370 ("[I]t is safe to estimate that mental illnesses cost the United States at least \$200 billion per year.").

186. SURGEON GENERAL REPORT, *supra* note 14, at 4.

187. *Id.* The "disability-adjusted life year" is a measure used "to quantify the burden of diseases, injuries, and risk factors . . . based on years of life lost due to premature death and years of life lived in less than full health . . ." WORLD HEALTH ORG., THE GLOBAL BURDEN OF DISEASE: 2004 UPDATE 2 (2008) [hereinafter 2004 GLOBAL BURDEN OF DISEASE STUDY].

188. See 2004 GLOBAL BURDEN OF DISEASE STUDY, *supra* note 187, at 3.

189. *Id.* at 43.

190. *Id.*

191. *Id.* at 44 tbl. 13.

192. *Id.* at 42, 44 tbl. 3 (Unipolar major depressive disorder is the number one cause of lost years of life, and alcohol abuse is the number four cause, in upper-income countries; globally, major depressive disorder is the number three cause and alcohol abuse is in the top twenty.)

193. SURGEON GENERAL REPORT, *supra* note 14, at 20; see Carolyn M. Levinson & Benjamin G. Druss, *The Evolution of Mental Health Parity in American Politics*, 28 ADMIN. & POL'Y MENTAL HEALTH 139, 142 (stating that mental health parity was an amendment to the VA/HUD bill and signed into law in 1996).

created a nearly sixty percent increase in overall healthcare costs.<sup>194</sup> Thus, assuming mental health costs have kept pace with general medical inflation, a sixty percent increase would currently place direct mental healthcare expenditures at about \$110 billion. Indirect costs are considered to be even more staggering. Mental illness results in lost productivity in the workplace,<sup>195</sup> increased disability costs due to mental health needs going untreated,<sup>196</sup> increased unemployment,<sup>197</sup> and, ironically, an increase in overall health care costs.<sup>198</sup> Unlike other health disorders, the indirect expenses of undertreated and untreated mental illness are believed to outweigh their direct costs; a 1998 estimate placed indirect mental health care costs at \$113 billion.<sup>199</sup>

Clearly the indirect costs of mental healthcare are substantial. Curbing these costs alone by effectively and efficiently treating mental illness would likely be sufficient to justify any potential increase in overall health insurance

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194. *Id.*

195. Ronald C. Kessler et al., *Prevalence and Effects of Mood Disorders on Work Performance in a Nationally Representative Sample of U.S. Workers*, 163 *AM. J. PSYCHIATRY* 1561, 1564 (2006). This study found that persons suffering bipolar disorder lost the equivalent to 65.5 workdays per year and persons with major depressive disorder lost the equivalent to 27.2 workdays per year due to their illness. Absenteeism—failing to report to work—accounted for 27.7 lost workdays per year among bipolar disorder sufferers and 8.7 lost workdays per year among those suffering major depressive disorder. *Id.* at 1563 tbl. 2. However, more lost productivity is created by presenteeism—where employees report to work but perform inefficiently. *Id.* Presenteeism accounts for 35.3 days of lost work production and 18.2 days of lost work production among those with bipolar disorder and major depressive disorder, respectively. *Id.* at 1562-63 tbl. 2. That presenteeism accounts for much more lost productivity than absenteeism results in the fact that productivity loss is essentially invisible to employers. Walter F. Stewart et al., *Cost of Lost Productive Work Time Among U.S. Workers with Depression*, 289 *JAMA* 3135, 3142-43 (2003). The Kessler study estimates that a total loss of 96.2 million workdays among the United States civilian workforce, accounting for a total projected salary-equivalent loss of \$50.7 billion per year. *Id.* at 1564.

196. Mary Jane England, *Capturing Mental Health Cost Offsets*, *HEALTH AFF.*, Mar.-Apr. 1999, at 91, 92 (“[D]epression often has the longest average length of disability and the highest probability of a second disability leave within one year.”).

197. Richard W. Goldberg et al., *Correlates of Long-Term Unemployment Among Inner-City Adults with Serious and Persistent Mental Illness*, 52 *PSYCHIATRIC SERVICES* 101, 101 (2001) (stating that unemployment rates are typically higher than eighty-five percent among persons with severe psychiatric disorders).

198. Sandra Davidson et al., *Cardiovascular Risk Factors for People with Mental Illness*, 35 *AUSTL. & N.Z. J. PSYCHIATRY* 196, 199 (2001) (reporting that persons with mental illness are more likely 1) to be smokers, 2) to be overweight or obese, 3) to not exercise and, 4) to drink at harmful levels; as a result, individuals who suffer from mental illness have a higher mortality rate due to cardiovascular disease).

199. Dorothy P. Rice & Leonard S. Miller, *Health Economics and Cost Implications of Anxiety and Other Mental Disorders in the United States*, 173 (Supp. 34) *BRIT. J. PSYCHIATRY* 4, 4-9 (1998).

costs created by parity. These expenditures often appear to be overlooked in the cost debate, likely due to the fact that direct costs are much easier to calculate. But even though some on both sides of the debate have long presumed an increase in healthcare costs, it does not appear clear that the direct costs of treating mental illness will necessarily result in higher overall costs to businesses and insurance providers upon implementation of full parity. The advent of managed care has proven to be an effective means to control direct mental healthcare costs. Whether that control results in truly equitable care is yet to be seen; however, as the main argument to date against mental health parity has been prohibitive costs, relevant research shows this is no longer a truly viable objection. Clearly, untreated and undertreated mental illness is costly to society. Both the direct and indirect costs of mental illness are staggering, likely topping \$200 billion per year.<sup>200</sup> The next section will discuss the paths some states have taken, both before and after passage of the MHPA, to control these costs and create parity for those suffering mental illness. It is arguable that many states, even prior to passage of the MHPA, created parity laws that rival or surpass that created by the MHPAEA. The question is whether those laws can be effective.

### III. STATE LAWS REGULATING MENTAL HEALTH PARITY

When the MHPAEA was signed into law on October 3, 2008, the Act was praised for its potential effect on eighty-two million Americans enrolled in self-funded group insurance plans and its prospective application to over 113 million Americans' health care coverage.<sup>201</sup> The raw numbers are impressive. But even prior to the passage of the 1996 MHPA, several states saw that parity was required and had taken the initiative to enact mental health parity statutes;<sup>202</sup> following passage of the 1996 Act, states began to pass new parity laws in earnest.<sup>203</sup> By the time the 110th Congress passed the MHPAEA, nearly every state had enacted some form of mental health parity law.<sup>204</sup>

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200. Kennedy, *supra* note 12, at 370.

201. *Parity at Last: Mental Health, Physical Health Get Equal Coverage*, AMEDNEWS.COM, Nov. 10, 2008, <http://www.ama-assn.org/amednews/2008/11/10/edsa1110.htm>.

202. Kjorstad, *supra* note 73, at 37.

203. See Sturm & Pacula, *supra* note 178, at 185 (Between 1997 and 1998, parity legislation passed in Arizona, Arkansas, Colorado, Indiana, Missouri, South Carolina, Texas, Vermont, Delaware, Georgia, South Dakota, and Tennessee.).

204. See Nat'l Conference of State Legislatures, *State Laws Mandating or Regulating Mental Health Benefits*, <http://www.ncsl.org/programs/health/mentalben.htm> (last visited Sept. 11, 2010) (noting that forty-six states currently have some form of parity legislation, and dividing that legislation into three categories—laws requiring “parity” for mental health

The state parity laws passed before and after the MHPA run the gamut. Some states passed laws that were essentially carbon copies of the federal MHPA, requiring nothing more of their insurance providers than that which was required by the federal law.<sup>205</sup> Other states passed laws that required more parity in terms of benefits offered, parity on par with that required by the MHPAEA.<sup>206</sup> Still other states required mental health parity above and beyond that required by the 2008 Act.<sup>207</sup> However, while many state legislatures appeared to see the weaknesses of the MHPA and its failure to achieve anything resembling true parity, restrictions on these laws, created mainly due to the application of ERISA, prevented state parity laws from having their intended effects.

A. *State Mental Health Parity Laws in Advance of the MHPA*

Advocates of mental health began lobbying for increased coverage for those suffering mental illness as early as the 1950s.<sup>208</sup> More than three decades later—thanks to political pressure from various mental health organizations coupled with the advent of more effective treatments, findings of biological causes for many serious mental illnesses, and more efficient cost control mechanisms created through managed health care—the 1990s brought about the first legitimate attempts at mental health law reform.<sup>209</sup> Beginning in 1991, the final decade of the 20th century saw no fewer than thirty-three states and the District of Columbia, as well as the federal government, pass varying decrees of mental health parity legislation.<sup>210</sup> The trend toward parity continued in the 21st century as more and more states sought to create a nondiscriminatory landscape for those suffering mental illness. By the passage of the MHPAEA in 2008, all but a small handful of states had passed some form of mental health parity legislation.<sup>211</sup>

Prior to the passage of the MHPA in 1996, five states had enacted some form of mental health parity legislation.<sup>212</sup> Texas and North Carolina were the first states in the union to pass parity statutes, enacting legislation five years prior to the MHPA, in 1991.<sup>213</sup> Two years later, Massachusetts

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benefits; laws mandating minimum mental health benefit; and, laws mandating the offering of mental health benefits).

205. See, e.g., ALASKA STAT. § 21.54.151 (2006).

206. See, e.g., KY. REV. STAT. ANN. § 304.17A-661 (LexisNexis 2000).

207. See, e.g., CONN. GEN. STAT. ANN. §§ 38a-488a(a), 38a-514(a) (West 2007).

208. Sturm & Pacula, *supra* note 178, at 183.

209. *Id.* at 182-83, 184.

210. 2000 GAO REPORT, *supra* note 47, at 8.

211. Nat'l Conference of State Legislatures, *supra* note 204 (reporting that as of December 2008, at least 46 states had passed parity legislation).

212. Kjorstad, *supra* note 73, at 37.

213. *Id.* at 38 chart 1.



became the third state to pass parity legislation.<sup>214</sup> While clearly these states were ahead of every other state, as well as the federal government, in terms of seeking equality for mental illness, the laws enacted did little for the overall population of individuals who suffer from these diseases for one main reason: the first three parity laws only applied to state employees.<sup>215</sup> The first individuals in this country to receive some level of parity were state employees. Similarly, many would argue that the first individuals to receive the benefits of *meaningful* parity legislation on a federal level were federal employees.<sup>216</sup>

While the 1991 Texas statute and the 1993 Massachusetts statute only applied to state employees, both laws were implemented as a pilot program for state employees.<sup>217</sup> Both states have subsequently expanded the coverage of the law to regulate private health care plans as well.<sup>218</sup> Between 1994 and the passage of the MHPA in 1996, Maine, Maryland, Minnesota, New Hampshire, and Rhode Island passed mental health parity legislation that applied to all state-regulated insurance providers. Each of these state laws was more comprehensive than the federal law enacted in 1996.

In June 2000, the National Institute of Mental Health's National Advisory Mental Health Council (NAMHC) issued its final report to Congress on the issue of parity in mental health insurance.<sup>219</sup> In that report, the NAMHC reviewed the effects of parity legislation with regard to a variety of subtopics. Included in the report was information on state parity legislation enacted both prior to and after the passage of the 1996 MHPA.<sup>220</sup> Subsequent research focused specifically on parity legislation enacted prior to the MHPA.<sup>221</sup> The NAMHC report classified variations in state law with regard to six issues: 1) categories of mental health mandates; 2) how the legislation defined mental illness; 3) whether the laws mandated coverage of chemical dependency; 4) whether the laws required insurers to provide the same terms and conditions for mental and physical illnesses; 5) whether the law exempted small employers; 6) whether the law contained cost increase exemptions.<sup>222</sup>

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214. *Id.*

215. *Id.* at 37.

216. See *infra* Part IV.B for discussion of the FEHB.

217. See Kjorstad, *supra* note 73, at 37.

218. See *id.*

219. See NAMHC REPORT, *supra* note 164, at 3.

220. See *generally id.* at 8-9.

221. See e.g., Kjorstad, *supra* note 73, at 37.

222. NAMHC REPORT, *supra* note 164, at 41 tbl. II; see also Kjorstad, *supra* note 73, at 37.

The six categories set forth by the NAMHC are helpful in distinguishing between state laws and the federal law. As will be shown, the 1996 MHPA was much less comprehensive than any of the state laws enacted prior to its passage. With regard to the first category—types of mental health parity mandates—the NAMHC divided parity mandates into three areas: “mandatory inclusion” benefits; “mandated benefit offerings”; and, “mandated if offered” benefits.<sup>223</sup> Mandated if offered legislation, that which requires complicity with parity provisions only if the insurer provides mental health coverage, is what the MHPA and the MHPAEA created, and is the least restrictive form of mandated benefits offering.<sup>224</sup> Four out of the five states that passed comprehensive parity legislation prior to passage of the MHPA required mental health benefit mandates surpassing those in the 1996 Act.<sup>225</sup> Only the fifth, Minnesota, enacted a benefits mandate similar to that passed in the MHPA, although it also covered substance abuse.<sup>226</sup>

Minnesota’s parity legislation, passed in 1995, mandates mental health coverage for HMOs, but only requires parity if mental health coverage is offered in individual and group plans.<sup>227</sup> Three of the other four states that enacted parity legislation prior to the MHPA—Maryland, New Hampshire, and Rhode Island—mandated coverage of mental health benefits no less restrictive than those benefits offered for physical health.<sup>228</sup> The fourth state—Maine—mandated coverage of mental health benefits in group insurance plans, and mandated the offering of equitable mental health coverage in individual plans.<sup>229</sup> Thus, in at least some respects, all five states that passed parity legislation prior to enactment of the MHPA required insurance carriers to provide mental health coverage, something the MHPA failed to do. As will be discussed further below, this requirement has not had a great effect on those suffering from mental illness, mainly due to federal restrictions in applicability of state law in this area.<sup>230</sup> The MHPAEA of 2008 does not extend the scope of the MHPA in this very important respect, and fails to mandate mental health coverage by insurers.

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223. NAMHC REPORT, *supra* note 164, at 43.

224. See, e.g., 29 U.S.C. § 1185a(b)(1) (2006) (defining “mandated if offered” legislation).

225. See NAMHC REPORT, *supra* note 159, at 8, 41-42 tbl. II (comparing state mental health parity statutes).

226. *Id.*

227. See MINN. STAT. ANN. § 62Q.47 (West 1995).

228. See MD. CODE ANN., HEALTH-GEN. § 19-703.1(b) (LexisNexis 2005); MD. CODE ANN., INS. § 490V (1994); N.H. REV. STAT. ANN. § 414:18-a (1994); R.I. GEN. LAWS § 27-18.6-2 (2002); see R.I. GEN. LAWS § 27-18.6-4 (2002).

229. ME. REV. STAT. ANN. tit. 24, § 2325-A (2000).

230. See *generally infra* footnote 249 and accompanying text.

The second category the NAMHC used to distinguish state parity statutes was the definition of mental illness in state legislation.<sup>231</sup> Specifically, the NAMHC distinguished between state statutes that provide parity for a broad category of mental illness versus state statutes that provide parity only for “serious mental illness[es].”<sup>232</sup> Opponents of parity legislation have often decried the notion of requiring insurers to offer coverage parity for mental illnesses as defined in nationally and internationally recognized objective authorities, such as the *Diagnostic and Statistical Manual of Mental Disorders*.<sup>233</sup> If parity is required at all, these opponents would suggest that the definition of mental illness be limited to a defined set of severe mental illnesses, or left to the coverage provider to determine on a medical

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231. NAMHC REPORT, *supra* note 164, at 8, 42 tbl. II. The NAMHC Report divides states’ parity legislation into two classes—those that provide “broad-based mental illness coverage” and those that limit coverage parity to “serious mental illness[es].” *Id.* at 8. “Broad-based mental illness coverage’ [is] defined to include all mental disorders listed in the American Psychiatric Association’s *Diagnostic and Statistical Manual* (4<sup>th</sup> edition) and/or the mental disorders in the World Health Organization’s *International Classification of Diseases*. *Id.* at 8, n.6. Some States allow health plans to define the scope of the mental health benefit. *Id.* at 40 tbl. ID. Several States narrow the scope of the statute by requiring coverage for ‘serious mental illness,’ most commonly defined as including schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, schizo-affective disorder, and delusional disorder. *Id.* at 38 tbl. IB; Kjorstad, *supra* note 73, at 39. See also *id.* at 37 (“[M]any states utilize the biologically based definition of mental illness, as it is more widely accepted by insurance companies and politicians.”).

232. NAMHC REPORT, *supra* note 164, at 8. The broad-based definition statutes, however, included laws that left open the determination of coverage to providers, as well as laws that mandated coverage for all mental illnesses as defined in an objective manual. See *id.* at 37 tbl. IA. Thus, the MHPA is described as a “broad-based” legislation, but the Act did not require insurance providers to rely on an objective manual, and instead left mental illness determinations up to the provider. Marcia C. Peck & Richard M. Scheffler, *An Analysis of the Definitions of Mental Illness Used in State Parity Laws*, 53 PSYCHIATRIC SERVICES 1089, 1091 (2002). It has been noted, however, that when the term “mental illness” has been used in federal legislation, it traditionally has been interpreted to include all disorders in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. *Id.* at 1090. It is clear from the application of the MHPA, and the language and understanding of the MHPAEA, that the federal parity legislation is designed to leave the definition of mental illness, for coverage purposes, to the insurers.

233. See 154 CONG. REC. H1285 (daily ed. Mar. 5, 2008) (statement of Rep. Deal) (Representative Nathan Deal argued that including coverage of all illnesses in the DSM would mean that insurers were required to provide coverage for things such as caffeine addiction and jet lag.).

necessity basis.<sup>234</sup> The MHPAEA has granted the wish of the opposition, as did its predecessor.<sup>235</sup>

Since passage of the MHPA, many state legislatures have taken it upon themselves to define more expansively the term mental illness. However, of the five states with parity legislation in effect prior to the MHPA, it is not clear that any had a truly broad-based definition of mental illness. The Maryland statute is interpreted as a broad-based statute, although it does not specify criteria based on an objective mental health manual.<sup>236</sup> The NAMHC Report refers to Minnesota's parity legislation as a broad-based definitional statute.<sup>237</sup> However, a 2002 study shows that Minnesota in fact leaves the definition of mental illness to individual health plans.<sup>238</sup> Unlike the NAMHC Report, the researchers for the 2002 study would not classify as "broad-based" a statute that leaves the definition to the provider.<sup>239</sup>

According to the 2002 study, New Hampshire and Rhode Island are the only two pre-MHPA parity states that currently boast legislation with broad-based definitions of mental illness.<sup>240</sup> However, in 1994 when the states' original parity laws were passed, New Hampshire employed a biologically

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234. See 154 CONG. REC. H1285 (Representative Deal argues that federal legislation should be focused on serious biologically based mental disorders.).

235. See Paul Wellstone and Pete Domenici Mental Health Parity Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512(a)(4), 122 Stat. 3881, 3884 (defining "mental health benefits" as: "benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law."). The MHPAEA definition replaced the description in the MHPA, which defined "mental health benefits" as: "benefits with respect to mental health services, as defined under the terms of the plan or coverage []." Pub. L. No. 104-204, § 712(e)(4), 110 Stat. 2945, 2947. Thus, the MHPA definition explicitly excluded benefits for treatment of substance abuse or chemical dependency.

236. Peck and Scheffler, *supra* note 232, at 1091 n. c. Maryland's parity statute covers "mental illness and emotional disorders." *Id.*

237. NAMHC REPORT, *supra* note 164, at 41 tbl. II.

238. Peck and Scheffler, *supra* note 232, at 1090.

239. See *id.* at 1090 (Minnesota, Indiana, and New Mexico were not included in the analysis because these states leave the definition of mental illness to the individual health plan.). The NAMHC Report referred to the MHPA definition of mental illness as "broad" as well, even though it allows plans to define mental illness. Pub. L. No. 104-204, § 712(e)(4), 110 Stat. 2947 (1996); NAMHC REPORT, *supra* note 164, at 41.

240. Peck and Scheffler, *supra* note 232, at 1091. New Hampshire passed a 2002 amendment to expand coverage to all mental disorders in the DSM (except chemical dependence), and Rhode Island passed a 2001 bill that included all disorders in the DSM and ICD (except mental retardation, learning disorders, motor skills disorders, and communication disorders). *Id.* n. d & f.

based definition of mental illness,<sup>241</sup> and Rhode Island provided a “serious mental illness” definition.<sup>242</sup> Maine’s pre-1996 legislation has been interpreted by lawmakers to provide a “serious mental illness” definition, although the statute fails to use that term.<sup>243</sup> While three of the states with pre-1996 laws were said to have “restricted” the definition of mental illness, and thus also the level of required coverage of mental illness, it must be remembered that each of these states *mandated* coverage of benefits for these illnesses, where the MHPA (and the MHPAEA) mandate no coverage whatsoever.

The third distinguishing category used in the NAMHC Report was coverage of substance abuse. One of the most important features of the MHPAEA is its inclusion of parity in coverage for substance use disorder benefits, notably absent from the 1996 legislation.<sup>244</sup> While the importance of this addition to the new federal law will be discussed in more detail below, for purposes of this Section it is important to note that two of the five states with pre-1996 parity legislation included coverage of chemical dependency in their original statutes: Maryland and Minnesota.<sup>245</sup> Only New Hampshire failed to add substance abuse disorders to its parity statute prior to enactment of the MHPAEA.<sup>246</sup> These state legislatures were aware that creating parity for mental illness benefits could not be truly beneficial without including parity language for chemical dependency. It is now widely believed that as many as fifty percent of the mentally ill population also suffers from chemical dependency.<sup>247</sup> Thus, it is imperative that substance abuse disorders be afforded the same level of protection as mental illnesses.

The fourth category the NAMHC Report used to distinguish state parity laws was whether the law required parity in terms and conditions of insurance contracts.<sup>248</sup> One of the aspects of the MHPA that incensed mental health advocates, and caused the law to have little or no effect on

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241. *Id.* at n. d (defining mental illness to include “schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, paranoid and psychotic disorders, panic disorders, and autism”).

242. *Id.* at n. f (defining “serious mental illness” as “schizophrenia and schizoaffective, bipolar, major depressive, obsessive-compulsive, and delusional disorders”).

243. *Id.* at 1092 tbl. 2, n. f (covering schizophrenia, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic disorder, autism, paranoia, and psychosis).

244. See discussion *infra* Section IV.A.

245. See MD. CODE ANN., HEALTH-GEN. §§ 19-703.1, 8-101 (LexisNexis 2005); MINN. STAT. § 62Q.47 (2009).

246. H. 762, Ch. 204.

247. NAMI Dual Diagnosis Report, *supra* note 98 (finding the drug most commonly abused to be alcohol, followed by marijuana and cocaine, and noting that prescription drugs are also abused).

248. NAMHC REPORT, *supra* note 222, at 41, tbl. II.

achieving true parity, was that the law only applied to annual and lifetime benefits. As was expected, insurance companies began placing more and more restrictions on the terms and conditions of contracts, essentially making mental health benefits even less comparable to physical benefits than they had been prior to the MHPA.<sup>249</sup> Again, it was not until passage of the MHPAEA that Congress corrected this gaping loophole.<sup>250</sup> But as with many of the other shortcomings of the MHPA, the states that enacted earlier legislation again demonstrated forethought. All five pre-1996 parity states enacted laws with stricter parity requirements than the MHPA with regard to the terms and conditions of insurance contracts.<sup>251</sup>

The final two categories used to distinguish parity laws in the NAMHC Report were exemption categories: small employer exemptions and cost exemptions.<sup>252</sup> Both types of exemptions existed in the MHPA, and both were reintroduced in the MHPAEA. The cost exemption is critically low in the MHPAEA,<sup>253</sup> and many states have provided either no cost exemption or a cost exemption higher than that allowed by the federal statute. Moreover, the small employer exemption has often been charged as one of the key reasons for lack of access for many mental illness sufferers. Prior to enactment of the 1996 Act, only one of the five states with parity legislation – Rhode Island – had a cost exemption provision.<sup>254</sup> Rhode Island also had a small employer exemption; Maine was the only other state with a small employer exemption.<sup>255</sup> The fact that many states have not provided a small business exception is extremely important, especially since the MHPAEA reapplies the small business exception of the 1996 Act. Because ERISA preempts more restrictive state statutes with regard to self-funded employer insurance, state statutes without small business exemptions are able to assist more citizens in achieving true parity.<sup>256</sup>

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249. 2000 GAO REPORT, *supra* note 47, at 5 (finding that as of 1999, of the insurers in compliance with the MHPA, 87% had instituted additional restrictions on coverage resulting in fewer mental health benefits being covered than physical benefits).

250. See discussion *infra* Section IV.A.

251. NAMHC REPORT, *supra* note 164, at 8. See also *id.* at 41 tbl. II.

252. *Id.* at 44. Small employer exemptions typically provide that employers with less than 25 or 50 employees do not have to abide by the parity rules; cost exemption statutes provide an exemption from parity requirements if an insurers costs rise due to implementation of parity. *Id.*

253. See discussion of the MHPAEA cost exemption *infra* Section IV.B.

254. See R.I. GEN. LAWS § 27-18-3 (1994).

255. ME. REV. STAT. ANN. tit. 24, § 2325-A (1995). However, Maine's small employer exemption only applied to businesses with *twenty* or fewer employees, rather than the federal statutes exemption for businesses with *fifty* or fewer employees. § 2325-A.

256. Janet L. Kaminski, *Self-Insured Benefit Plans and Insurance Mandates*, OLR RESEARCH REPORT (2005), available at <http://www.cga.ct.gov/2005/rpt/2005-R-0753.htm>. Most small businesses cannot afford to be self-insured, and thus do not fall within the purview of ERISA;

While a handful of states had considered and even passed mental illness and substance abuse parity legislation prior to passage of the MHPA, once the federal legislature cracked the door to mental health parity the floodgates opened. During the twelve years between passage of the MHPA and the MHPAEA, nearly every state passed some form of parity legislation, some more meaningful than others. It is questionable, though, whether even the more comprehensive state laws were capable of creating equitable treatment for mental illness, mainly due to ERISA preemption.

*B. The MHPA Sparks a Rapid Increase in State Parity Legislation, but Can It Be Effective?*

When Congress passed the MHPA in 1996, only five states had passed mental health parity legislation.<sup>257</sup> However, as the previous section discusses, each of these early parity laws was more comprehensive than the federal law enacted by the MHPA. During the twelve years between passage of the MHPA and the MHPAEA, forty-one additional states passed mental health parity laws.<sup>258</sup> The number of individual pieces of parity legislation was certainly much higher, considering that in 2001 alone, seventy-six separate pieces of parity legislation were considered by thirty-four states.<sup>259</sup>

From 1997 through 2000, approximately the period of time the MHPA was intended to last prior to sunset, thirty-four separate states enacted parity legislation.<sup>260</sup> According to the 2000 GAO Report, fourteen states and the District of Columbia passed parity laws in the year immediately following passage of the MHPA.<sup>261</sup> The following year, 1998, eight additional states passed parity laws, and Kansas and West Virginia amended their 1997 legislation.<sup>262</sup> In 1999, three new states – Hawaii, New Jersey, and

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however, because many large companies are self-insured, ERISA preempts state laws with respect to them. Thus, state statutes do not apply to many large businesses, and if the state statute further exempts small businesses, it will affect very few companies at all. *Id.*

257. See discussion *infra* Section III.A.

258. See Nat'l Conference of State Legislatures, *supra* note 204, at 4-17.

259. See Beth Mellen Harrison, *Mental Health Parity*, 39 HARV. J. ON LEGIS. 255, 261 n. 56 (2002); see also Dana L. Kaplan, *Can Legislation Alone Solve America's Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J., 325, 344-45 (2005).

260. 2000 GAO REPORT, *supra* note 47, at 41 tbl. 30.

261. *Id.* In 1997 Alaska, Arkansas, Delaware, Indiana, Kansas, Louisiana, Missouri, Montana, Nevada, North Carolina, South Carolina, Tennessee, Texas, and West Virginia enacted parity laws. *Id.*

262. *Id.* (adding Arizona, Colorado, Florida, Georgia, New Mexico, New York, South Dakota, and Vermont to the list of states with new parity legislation). Of note, Vermont's parity statute has generally been considered one of the most comprehensive parity statutes.

Pennsylvania – enacted parity legislation, and Delaware enacted new legislation.<sup>263</sup> And in 2000, fourteen states implemented a new form of parity legislation, either creating new legislation or amending an existing law.<sup>264</sup> Thus, by the end of 2000, thirty-nine states had enacted some form of parity. Over the next eight years prior to Congress's enactment of the MHPAEA, seventeen of the remaining twenty-one states enacted parity laws.

With forty-six states enacting parity legislation between 1996 and 2008, one would expect the individual laws to be somewhat different. This expectation proves correct, and this is one of the reasons why the federal government should enact parity legislation that encompasses the best of the state laws. In twelve years nearly every state has passed their own version of parity legislation, and while some states have strived to create the most comprehensive laws possible, other states have merely enacted laws that do little more than the MHPA. Thus, as the MHPAEA goes into effect in 2010, these states are likely to do nothing. Essentially, the states that have laws in place requiring their insurance industry to comply with the federal law need do nothing. As previously stated, the state laws run the gamut: from laws requiring nothing more than what federal legislation requires,<sup>265</sup> to the most comprehensive parity laws, mandating coverage of mental illness and requiring that coverage be equitable to coverage of medical and surgical benefits.<sup>266</sup>

These differences in laws are not beneficial to anyone. Which state a person lives in will determine if, and to what extent, his or her treatment for mental illness is covered. In one state, a person participating in a group health plan might find that *all* treatments for any mental disorder are covered by their insurance plan, and in fact that coverage might be mandated by state law.<sup>267</sup> In the neighboring state, however, that same person might find that not a single mental disorder is covered by their

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Margo Rosenbach, *Mental Health and Substance Abuse Parity in Vermont: Employer Perspectives*, ISSUE BRIEF, Sept. 2003, at 1, 1.

263. 2000 GAO REPORT, *supra* note 47, at 44-54 tbl. 30.

264. *Id.* at 41-58 (listing the states with first-time legislation as: Alabama, California, Connecticut, Kentucky, Nebraska, Oklahoma, Oregon, and Virginia; and the states with amended legislation as: Indiana, Louisiana, Missouri, Montana, Nevada, New Mexico, and Tennessee).

265. In fact, Wyoming and Wisconsin have no parity statutes whatsoever. LARA GREGORIO, *MENTAL HEALTH PARITY* (2009), [http://www.nationaleatingdisorders.org/uploads/file/EDparityanddescription\(2\).pdf](http://www.nationaleatingdisorders.org/uploads/file/EDparityanddescription(2).pdf); see also *Join Together*, No Parity in New Wisconsin Health Plan, Critics Charge, *JOINTOGETHER.ORG* (2009), <http://www.jointogether.org/news/headlines/inthe news/2009/no-parity-in-new-wisconsin.html>.

266. Vermont, for example, not only mandates full parity, it mandates it for individual as well as group insurance providers. VT. STAT. ANN. tit. 8, § 4089b (2001).

267. See, e.g., §§ 4089b(b)-(c).



insurance plan, and nothing in the state law prohibits that total lack of coverage. In fact, this latter scenario reflects how both the MHPA and MHPAEA treat the situation.<sup>268</sup>

Even in different states whose statutes appear to mandate coverage of the same illnesses – all “severe” or “serious” mental illness – one will find that the legislatures have defined those terms in a different way.<sup>269</sup> This “patchwork” of state laws makes it extremely difficult to determine accurately the effect of parity legislation on those suffering mental illness. The fact is, Americans suffering from mental illness are not only receiving disparate treatment as compared to Americans suffering physical illnesses. In many cases they are also receiving disparate treatment as compared to citizens suffering from mental illness in states whose legislatures have passed more comprehensive parity legislation. For instance, as of 2002, nine state legislatures, like the federal Congress, provided for some type of cost increase exemption, no longer requiring their insurance companies to provide equitable mental health coverage upon showing a cost increase due to parity.<sup>270</sup> Similarly, seventeen states in 2002 provided small employer exemptions in their state statutes, thereby authorizing certain employers to provide inequitable mental health coverage.<sup>271</sup> Substance abuse disorders, discussed above as being linked to fifty percent of mental illnesses, remained excluded by nine of the forty-six states with parity legislation as of 2008.<sup>272</sup>

However, this legal patchwork is not the only downfall to leaving truly comprehensive parity legislation to the states. State laws have been preempted from day one by ERISA. Even prior to passage of the MHPA,

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268. See discussion of the MHPA *supra* Section II.A.; see also discussion of the MHPAEA *infra* section IV.

269. See, e.g., CAL. INS. CODE § 10144.5 (2005) (defining “severe” mental illness to include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa); DEL. CODE ANN. tit. 18, § 3343 (1999) (defining “serious” mental disorder to include schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizoaffective disorder and delusional disorder); MONT. CODE ANN. § 33-22-706(6) (2007) (defining “severe” mental illness to include schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive compulsive disorder and autism); R.I. GEN. LAWS § 40.1-5.4-7(10) (2006) (stating that “serious” mental illness includes “schizophrenia, bi-polar disorders as well as a spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation, alcohol, or drug abuse or anti-social behavior”).

270. See VERMONT PARITY STUDY, *supra* note 180, at ex. I.1 (noting that twenty-three states at the time of the study had no cost increase exemption).

271. *Id.*

272. Nat’l Conference of State Legislatures, *supra* note 204, at 4-17.

ERISA limited the application of the early parity laws. ERISA preempts state law for all self-insured employer health insurance plans. Thus, no matter how comprehensive a state law, its restrictions do not apply to these plans. According to a report by the Employee Benefit Research Institute ("EBRI"), as of 2000, fifty million workers and their dependents received benefits through employer sponsored self-insured group health plans, representing thirty-three percent of the 150 million Americans in private, employment-based plans.<sup>273</sup> In 2006, the number of workers in self-insured plans, and thus the number of Americans to whom comprehensive state parity laws did not apply, had increased dramatically to 73 million.<sup>274</sup>

It appears that most states saw the passage of the MHPA in 1996 as a sign that mental health parity was affordable. This sign led to the enactment of parity laws in forty-one states over the course of the next twelve years. However, the patchwork nature of the state legislation, the preemption of state insurance laws by the MHPA in terms of self-insured employer health plans, and the minimal benefits provided by the MHPA itself, assured that individuals suffering from mental illness would continue to receive inequitable treatment. On October 3, 2008, as part of an economic bailout package aimed at rescuing the nation's banking and mortgage systems, among others, the U.S. Congress passed the first piece of meaningful federal parity legislation in at least twelve years.

#### IV. THE MENTAL HEALTH PARITY AND EQUITABLE TREATMENT ACT OF 2008

##### A. *Twelve Years – The Differences Between the 1996 and 2008 Acts: How the MHPAEA Seeks to End Discrimination*

According to James Jordan, executive director of the National Alliance on Mental Illness, enactment of the MHPAEA ended almost twenty years of struggle and eliminated discriminatory practices by some insurance companies.<sup>275</sup> This sentiment was echoed by one of the bill's major sponsors, Senator Pete Domenici (R-N.M.), who argued that the new law ushers in a new era of mental healthcare.<sup>276</sup> Still others trumpeted the

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273. Self-Insurance Inst. of Am., *Self-Insured Group Health Plans*, <http://www.siaa.org/i4a/pages/Index.cfm?pageID=4546> (last visited Sept. 11, 2010).

274. William Pierron & Paul Fronstin, *ERISA Pre-emption: Implications for Health Reform and Coverage*, EMPLOYEE BENEFIT RESEARCH INSTITUTE ISSUE BRIEF, Feb. 2008, at 1, 11, available at [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_02a-20082.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf).

275. Christopher Guadagnino, *Historic Mental Health Parity Law Passes*, PHYSICIAN'S NEWS DIGEST (2008), <http://www.physiciansnews.com/spotlight/1108pa.html>.

276. Amy Novotney, *Landmark Victory: The New Mental Health Parity Law Dramatically Expands Coverage of Mental Health Treatment*, MONITOR ON PSYCHOL., Nov. 2008, at 27, 28, available at <http://www.apa.org/monitor/2008/11/parity.html> (quoting Senator Domenici

passage of the MHPAEA. Representative Patrick Kennedy, the main House sponsor, voiced his excitement about the bill's passage.<sup>277</sup> And American Psychological Association CEO Norman B. Anderson sees the passage of the MHPAEA as removing "a significant barrier to receiving effective treatments for mental and substance abuse disorders."<sup>278</sup>

This excitement likely sounds familiar to anyone who remembers the enthusiasm following the passage of the MHPA. A notable bit of praise following that Act came from then Executive Director of the National Alliance on Mental Illness, Laurie Flynn:

American families in communities large and small who are coping with the devastating effects of severe mental illnesses can breathe a little easier knowing their loved ones are covered by insurance. This modest anti-discrimination law eliminates the double standard held against millions suffering from brain disorders and gives them renewed hope for reestablishing full and productive lives.<sup>279</sup>

Following passage of the MHPAEA, however, there appears to be much more to cheer about. Clearly, the law is better than the original federal legislation, even if it does not live up to some of the most comprehensive state legislation or some of the prior versions of parity proposed in Congress.<sup>280</sup> And it was twelve long years in the making.

It is impossible to say whether the MHPAEA would have passed were it not for the economic meltdown America faced in late 2008,<sup>281</sup> but the

as saying, "No longer will we allow mental health to be treated as a stepchild in the health-care system.")

277. "Because of your hard work, the American dream will no longer be rationed by diagnosis." *Id.* at 29.

278. *Id.* at 28.

279. NAMI Press Release, *supra* note 105.

280. For example, in a version of H.R. 1424 debated on the floor of the House on March 5, 2008, the following language would have been added to the MHPAEA:

"MINIMUM SCOPE OF MENTAL HEALTH AND SUBSTANCE-RELATED DISORDER BENEFITS.—

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides any mental health or substance-related disorder benefits, the plan or coverage shall include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association."

154 CONG. REC. H1279 (daily ed. Mar. 5, 2008) (text of House Resolution 1424).

The final version of the MHPAEA passed by the Senate again left the determination of which illnesses group plans will cover to the individual providers.

281. While it is uncertain whether the Senate would have ever taken up H.R. 1424 if the House had passed the original bailout package, it is clear that mental health parity was a major topic of discussion during the 110th Congress. On February 12th, 2007, the Senate introduced S. 558, the Mental Health Parity Act of 2007. CRS REPORT, *supra* note 110, at 1.

economic crisis proved to be at least a factor in the passage of a new parity law. With multiple banks and lending institutions being bought-out or on the brink of collapse, and still others requesting government money to bail them out of potential failure, discussion of an economic bailout package began in the early fall. In late September, with the leaders of both the Democratic and Republican Parties warning of a global financial meltdown if a bailout of the financial industry was not passed, the House rejected a \$700 billion bailout bill.<sup>282</sup> The 2008 presidential and congressional elections were just over a month away, and political posturing was at its peak. Although the House failed to pass its version of an economic bailout, almost six months earlier, on March 5, 2008, it had passed the MHPAEA. In what may have been simply a savvy political move,<sup>283</sup> accompanied by a stroke of luck in favor of parity advocates, the Senate chose this House bill – H.R. 1424, originally introduced in March 2007 – to pass the economic bailout package.<sup>284</sup>

In amending ERISA, the PHSa, and the Internal Revenue Code, the MHPAEA has responded to many, if not all, of the concerns created by the MHPA. The two laws are markedly different. While the MHPAEA, like its predecessor, required a one year wait prior to implementation,<sup>285</sup> it has

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Two days later, the Health, Education, Labor, and Pensions Committee approved the legislation, and less than a month later the House introduced H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act. *Id.* at 11. In May, the Senate also introduced a children's version of the parity bill, the Children's Mental Health Parity Act (S. 1337), which would have amended the Social Security Act to provide equal coverage of mental healthcare under the State Children's Health Insurance Program. *Id.* at 12.

282. Carl Hulse & David M. Herszenhorn, *House Rejects Bailout Package*, 228-205; *Stocks Plunge*, N.Y. TIMES, Sept. 29, 2008, available at [http://www.nytimes.com/2008/09/30/business/30bailout.html?\\_r=1&scp=1&sq=House%20Rejects%20Bailout%20Package,%2028-205;%20Stocks%20Plunge&st=cse](http://www.nytimes.com/2008/09/30/business/30bailout.html?_r=1&scp=1&sq=House%20Rejects%20Bailout%20Package,%2028-205;%20Stocks%20Plunge&st=cse).

283. As the Constitution bars the Senate from initiating new spending bills, and the House had voted down the bailout package both parties' leaders felt was necessary, the Senate needed to find a piece of legislation on which to attach the bailout package. Nat'l Ass'n of Addiction Treatment Providers, *The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008: A Guide for Addiction Professionals and Treatment Providers*, NAATP VISIONS, Nov. 2008, at 1, 2, available at <http://www.naatp.org/pdf/newsletters/08novembersi.pdf>. The Senate used the H.R. 1424 – which had now been altered to reflect compromises between the two Houses of Congress – stripped the text of the original bill, and amended the bill to include the compromised version of parity legislation, the Senate's version of the economic bailout package, and various tax cuts and credits. *Id.* Thus, H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2008, became the 169 page Emergency Economic Stabilization Act of 2008. *Id.* The Act did contain twelve pages of parity. *Id.*

284. *Id.*

285. See MHPAEA, Pub. L. No. 110-343, §§ 512(a)(1), (b)(1), (c)(1), 122 Stat. 3881-93 (2008).

removed the sunset provision that existed in the MHPA.<sup>286</sup> Thus, it will take an Act of Congress to remove the provisions of the MHPAEA, rather than requiring a legislative continuation of the sunset every year until future legislation is passed, as was the case under the MHPA.<sup>287</sup> Congress's decision to not include a sunset provision in the new Act shows that its members, including parity opponents, have truly accepted the need for meaningful parity legislation and realize that parity legislation is practical and affordable. When the MHPA was passed, antagonism toward the measure was nearly as vociferous as the support. Thus, providing a sunset for the legislation in the event that it proved dramatically cost prohibitive, as many opponents predicted, was one of the only means by which to pass the legislation.<sup>288</sup> While not a major substantive change, removal of the sunset proves that parity, in some form or another, is here to stay.

The MHPAEA has, however, created major substantive changes to federal parity law as well. First and foremost, the MHPAEA finally has provided parity for the fifty percent of individuals suffering substance use disorder alongside their mental illness.<sup>289</sup> The term "mental health benefits" has now been replaced by the much more inclusive "mental health and substance use disorder benefits."<sup>290</sup> As discussed, one of the original sponsors of mental health parity on the federal level, Senator Paul Wellstone of Minnesota, had a family member who fell within the category of individuals suffering both mental illness and corresponding substance use disorder.<sup>291</sup> While Senator Wellstone did not live to see the passage of the MHPAEA and parity for substance use disorders,<sup>292</sup> his advocacy for these illnesses surely contributed to the passage of the new Act. The importance of the MHPAEA's inclusion of substance use disorders cannot be overstated. Not only does the law provide for at least a partial end to discrimination

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286. §§ 512(a)(5), (b)(5), (c)(5).

287. See e.g., *supra* note 127 (citing two Congressional acts that reauthorized the MHPA from 2003 to 2004 and from 2004 to 2005).

288. See *supra* section II (discussing opposition to the MHPA).

289. MHPAEA §§ 512(a)(4), (7), (8).

290. §§ 512(a)(7), (b)(7), (c)(7). Like its predecessor, the MHPAEA's treatment of substance use disorders mirrors its treatment of mental health benefits in that it leaves the definition of a substance use disorder up to the plan providers. §§512 (a)(4), (b)(4),(c)(4).

291. Levinson & Druss, *supra* note 5, at 139.

292. Senator Wellstone died in a tragic plane crash while campaigning in 2002. David E. Rosenbaum, *A Death in the Senate: A Liberal Voice Stilled*, N.Y. TIMES, Oct. 26, 2002, at A19.

against this group, it offers coverage of a disorder that many state laws still fail to provide.<sup>293</sup>

The most important changes implemented by the MHPAEA are changes to the initial subsections of Section 712 of ERISA,<sup>294</sup> Section 2705 of the PHSa,<sup>295</sup> and Section 9812 of the IRC.<sup>296</sup> After the MHPA was enacted, these sections were changed to include provisions requiring that group health plans provide equitable coverage in terms of aggregate lifetime and annual limits.<sup>297</sup> As discussed, these provisions left the door open for insurance providers to apply cost-containment measures to mental health benefits in virtually every aspect of their plans. In sweeping language, the MHPAEA has corrected this flaw.<sup>298</sup>

The MHPAEA now requires group health plans that offer mental health benefits to ensure that any financial requirements in the plan that are applicable to mental health or substance use disorders are “no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan.”<sup>299</sup> Furthermore, plans can no longer impose cost sharing requirements on individuals suffering mental health or substance use disorders, if those cost sharing requirements are not imposed on all individuals in the plan.<sup>300</sup>

Restrictive treatment limitations are also proscribed. Specifically, group health plans can no longer apply more restrictive treatment limitations to mental health and substance use benefits than “the predominant treatment limitations applied to substantially all medical and surgical benefits;” moreover, they cannot apply separate limitations applicable only to mental health and substance use benefits.<sup>301</sup> To be clear, the Act defines financial

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293. Nat’l Conference of State Legislatures, *supra* note 204 (“[A]t least 38 states” provide coverage for alcohol, drugs, or substance abuse. This suggests that as many as twelve states still fail to protect this population from discrimination.).

294. 29 U.S.C. §1185a (2000).

295. 42 U.S.C. §300gg-5 (2006).

296. 26 U.S.C. § 9812 (2006).

297. See *supra* section II (discussing the MHPA).

298. See MHPAEA, Pub. L. No. 110-343, §§ 512(a)(1), (b)(1), (c)(1), 122 Stat. 3881-89 (2008).

299. §§ 512(a)(1), (b)(1), (c)(1). It is important that each of the three amendments begins by discussing “financial requirements” in broad, generalized terms. If the law had used restrictive language, such that it would potentially prohibit discrimination as to certain financial requirements but not others, insurance providers would almost certainly use those loopholes to continue providing inequitable coverage. In fact, this is exactly what happened under the MHPA.

300. §§ 512(a)(1), (b)(1), (c)(1). Each of the three amendments contains the language “there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits.”

301. §§ 512(a)(1), (b)(1), (c)(1).

requirements to include deductibles, copayments, coinsurance, and out-of-pocket expenses; it defines treatment limitation to include limits on the frequency of treatment, number of visits, and days of coverage.<sup>302</sup> Importantly, however, these lists are not exhaustive – rather, they simply list the more common methods by which insurers had practiced discrimination under the MHPA.

Another method by which insurers had discriminated against the mentally ill was by limiting or eliminating out-of-network for mental illnesses and substance use disorders. The MHPAEA corrects this flaw as well.<sup>303</sup> No longer will insurance plans governed by ERISA or the PHSA be permitted to limit or disallow coverage for treatment provided by out-of-network providers to the mentally ill unless the same coverage is limited or disallowed for all members of the plan.<sup>304</sup> These amendments to the law are why the MHPAEA has been heralded as an introduction of full parity. While the MHPA only applied to annual and lifetime limits on coverage, the new law expressly prohibits discrimination by means of any type of restrictive financial requirements or treatment limitations.

It appears from the language of the MHPAEA that the new law will be able to realize its goals more certainly than did the MHPA. When reviewing the current versions of ERISA, the PHSA, and the IRC in light of the 2008 Act, it appears more evident than ever that the original law was nothing more than a symbolic gesture toward the plight of the mentally ill. Even without considering that insurance providers did *in fact* use every opportunity available to subvert the true purpose of the MHPA, the language of the law itself was simply one massive exception. The prohibitions against annual and lifetime benefits limitations *themselves* begged the question. “But, we can continue to discriminate with respect to every other manner of disparate financial requirement and treatment limitation, right?”

While the advent, and subsequent industry domination, of managed care admittedly makes it difficult to determine what the true long-term effect of the MHPAEA will be in terms of equitability, the legislature appeared to take that into consideration. In addition to barring unequal financial requirements and treatment limitations, the new law adds a subsection that expressly requires more transparency on the part of insurance providers with regard to medical necessity determinations.<sup>305</sup> In particular, the amendment states “the criteria for medical necessity determinations. . .shall be made available. . .to any current or potential participant, beneficiary, or

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302. §§ 512(a)(1), (b)(1), (c)(1).

303. MHPAEA, Pub. L. No. 110-343, § 512(a)(1), (b)(1), (c)(1) (2008).

304. §§ 512(a)(1), (b)(1), (c)(1).

305. § 512(a)(1).

contracting provider upon request.”<sup>306</sup> Moreover, the law requires that the reason for any denial of reimbursement or payment for mental health or substance use disorder services be made available to a beneficiary upon request.<sup>307</sup> While this language will obviously not end, or likely even dampen, the managed care debate – especially as it pertains to mental illness – it shows that the legislature is aware of the potentially negative role managed behavioral healthcare could play in the search for truly equitable treatment coverage for mental illness.

It is certain that the MHPAEA is a much better law than its predecessor. Not only does it appear that opponents of the legislation have changed their tune to some degree; it also seems that proponents in the federal legislature planted their feet more firmly and were much less willing to accept “compromises” that might seriously damage the potential of the law.<sup>308</sup> Compromises were still made, however, and the law is not as broad as it could have been. In fact, the law is not as broad as the version of H.R. 1424 that passed on March 5, 2008. From the time the House passed their version of the MHPAEA in March, to the time the President signed the bill into law on October 3, changes were made, provisions were deleted, and a *truly* expansive mental health parity law was left for another day.

*B. Can the MHPAEA Achieve its Goals – Could (Should?) More Have Been Done?*

In short, time will tell as to whether the MHPAEA is a sufficient attempt at true parity in coverage of mental and physical illness, or whether more must be done to fully protect the large portion of our society affected by diseases of the brain. Just months after passage of the new law, and months prior to its implementation, speculation was the only sure thing, and it began almost immediately.<sup>309</sup> Much of this speculation was positive and seemed to predict that the MHPAEA is a final step toward parity.<sup>310</sup> As the previous subsection discussed, the 2008 Act is a substantial improvement on the MHPA. However, the law is not as comprehensive as either the Senate bill

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306. § 512(a)(1).

307. § 512(a)(1).

308. There were still detractors, however. For an example of the opposition’s arguments that persisted, some of which eventually won out, see 154 CONG. REC. H1285 (daily ed. Mar. 5, 2008) (statements of Reps. Deal, Sullivan, Barton, Broun, McKeon, and Fallin).

309. Of course, initial speculation was that the law constituted “a massive triumph.” It may prove to be just that; however, passage of the MHPA created similar initial excitement that proved to be short-lived. See Novotney, *supra* note 276, at 27 (discussing the “landmark victory” for parity advocates).

310. See, e.g., Guadagnino, *supra* note 275 (reporting that the director of advocacy programs for the National Alliance of Mental Illness of New Jersey views the law as “a god-send”).



passed in September 2007,<sup>311</sup> or the House version of parity passed in March 2008.<sup>312</sup> More importantly, the law is not as comprehensive as a federally enacted benefits parity provision that has been in effect since January 1, 2001 – found in the Federal Employee Health Benefits Program (“FEHBP”).<sup>313</sup>

It is not the purpose of this article to discount the importance of the MHPAEA. But the errors of the past should not be repeated, and unquestioned praise should not be heaped upon this law until it has proven its merit. The MHPAEA retains various protective features from the original MHPA, which parity advocates argued could permit continued inequities in coverage.

First, the MHPAEA continues the same small employer exemption provided for in the MHPA, with essentially a clerical amendment.<sup>314</sup> While the federal definition of “small employer,” at least in terms of ERISA,<sup>315</sup> and the PHSA,<sup>316</sup> only includes companies with 50 or fewer employees this is not, by all definitions, a small company. In fact, with regard to the Americans with Disabilities Act, the federal government has demanded compliance from all businesses employing more than *fifteen* employees.<sup>317</sup>

It is not that fifty is necessarily an arbitrary number.<sup>318</sup> But knowing that parity has been shown not to be cost-prohibitive – likely, rather, cost beneficial – why should the law continue to provide a safe haven for discrimination? If the law is going to continue to provide an exemption to protect small employers, and the purpose of the law, in fact, is to protect the financial viability of these businesses, the law should provide an exemption for truly *small* businesses. If employers of fifteen or less are the only

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311. S. 558, 110th Cong. (2007).

312. H.R. 1424, 110th Cong. (2008). For example, the House version included a provision that would require plans providing mental health or substance use benefits to recognize any condition or disorder listed in the Diagnostic and Statistical Manual of Mental Disorders. §102(d).

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

314. MHPAEA, Pub. L. No. 110-343, §§ 512(a)(3), (b)(3), (c)(3), 122 Stat. 3881-89 (2008) (amending the small employer definition to include employers with only one employee in order to extend the exemption to employers residing in States that permit small employer groups to consist of one individual).

315. 29 U.S.C. §1185a (c)(1)(B)(2000).

316. 42 U.S.C. §300gg-5 (2006).

317. EQUAL EMP'T OPPORTUNITY COMM'N, THE AMERICANS WITH DISABILITIES ACT: A PRIMER FOR SMALL BUSINESSES 1 (2002).

318. According to a 1997 study, only 3-4% of companies with fewer than 50 employees were self-insured and thus had insurance plans governed by ERISA. M. Susan Marquis & Stephen H. Long, *Recent Trends in Self-Insured Employer Health Plans*, HEALTH AFF., May-June 1999, at 161, 165 ex. 4.

businesses allowed to forgo the requirements of the ADA, thus not being required to make reasonable accommodations for their disabled employees, the law should only extend such a minimal exception to its mental health parity provisions. Moreover, if mental healthcare is not only affordable but in fact pays for itself by potentially eliminating many of the substantial indirect costs associated with mental illness, it is arguable that no small employer exemption is really warranted at all. Small businesses might balk at being required to pay more for healthcare, and generally the argument is that they will drop insurance altogether, thus leaving more uninsured. But if these employers, as well as the general public, were sufficiently educated about the potential savings based on decreased absenteeism and presenteeism resulting from mental illness,<sup>319</sup> they might not be so quick to limit or remove coverage.

In addition to continuing the small employer exemption, the MHPAEA has provided a new version of an increased cost exemption.<sup>320</sup> The MHPA's cost exemption allowed group health plans to forgo the requirements of parity if compliance with the law resulted in an increase of one percent in the plan cost.<sup>321</sup> The MHPAEA has amended this language to provide an exemption to plans that see an increase of two percent in the first plan year.<sup>322</sup> After the first plan year, however, the cost exemption returns to the original one percent.<sup>323</sup> If coverage of mental illness is affordable, and can potentially reduce overall costs, there really should be no argument against a cost exemption. But certain states have reported increases in the overall costs of their plans in the first year, followed by a subsequent decline in costs.<sup>324</sup> Under the federal law, a plan can discontinue mental health benefits altogether or can resume inequitable coverage prior to seeing that eventual decline. While only about one percent of health plans dropped mental health benefits as a result of enactment of the MHPA,<sup>325</sup> that law provided so many loopholes for insurance providers so as to make it

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319. See *supra* Section III (discussing the savings that states have seen after enacting parity laws).

320. MHPAEA, Pub. L. No. 110-343, §§ 512(a)(3)(B), (b)(3)(B), (c)(3)(B), 122 Stat. 3881-89 (2008).

321. See, e.g., 29 U.S.C. § 1185a(c)(2) (2000).

322. See, e.g., MHPAEA § 512(a)(3)(B).

323. § 512(a)(3)(B).

324. See *supra* notes 183 and 184 and accompanying text (discussing the decline in costs that Texas, North Carolina, Ohio, and California saw following the enactment of parity legislation).

325. See 2000 GAO REPORT, *supra* note 47, at 17.

unnecessary to remove coverage. Again, time will tell whether more insurers will drop mental health benefits under this law.<sup>326</sup>

Like its predecessor, while the MHPAEA technically applies to all mental illnesses, it leaves the determination of which mental illnesses will receive protection from the Act to plan providers.<sup>327</sup> Similarly, which substance use disorders will receive protection from the Act will vary, depending on the language of individual healthcare plans.<sup>328</sup> Although the MHPAEA has included a provision requiring health plans to provide criteria for medical necessity determinations and reasons for treatment denials to beneficiaries,<sup>329</sup> the law does not require anything in particular in terms of which illnesses and treatments must be provided. When the House passed H.R. 1424 in March 2008, the bill required that if a group health plan offered mental health and substance use disorder benefits, it must provide coverage for all illnesses listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).<sup>330</sup> Many of the arguments on the floor of the House against passing the bill concerned this mandated coverage provision,<sup>331</sup> and the Senate required a concession to language mirroring the original law before they would accept the bill.<sup>332</sup>

Opponents of the inclusion of all DSM illnesses argue that it will require insurance providers to cover many less severe illnesses they might not otherwise cover.<sup>333</sup> Those supporting inclusion of the DSM say this is simply a "red herring"; the medical necessity requirements of insurance plans would limit unnecessary treatment coverage.<sup>334</sup> By failing to include the House language, Congress passed up an opportunity to show that the law will not stand for discriminatory treatment of any mental illness. What may

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326. The American Psychological Association (APA) does not believe this will happen; they argue that ninety-seven percent of health plans currently cover mental health and substance use benefits and will simply make minor adjustments throughout the plan to offset any potential costs. Am. Psychological Ass'n Practice Org., *The Wellstone-Domenici Mental Health Parity Act of 2008: Questions and Answers for Psychologists* (2008), <http://www.apa.practicentral.org/news/2008/wellstone-domenici.aspx>. The APA does not address, however, the plans that dropped coverage after the 1996 Act, and the potential for more dropped coverage in the face of fewer loopholes.

327. See, e.g., MHPAEA, Pub. L. No. 110-343, § 512(a)(4) (2008).

328. MHPAEA § 512(a)(4).

329. See, e.g., MHPAEA § 512(a)(1).

330. See 154 CONG. REC. H1274, 1279 (daily ed. Mar. 5, 2008).

331. See *generally id.* Congressmen Deal (GA), Barton (TX), Burgess (TX), and Buyer (IN) all cited the DSM as reasons they would vote against the bill. *Id.* at H1285-89.

332. See Depression and Bipolar Support Alliance, *Parity Update* (2008), [http://www.dbsalliance.org/site/PageServer?pagename=advocacy\\_parity](http://www.dbsalliance.org/site/PageServer?pagename=advocacy_parity).

333. See, e.g., 154 CONG. REC. H1286-89 (daily ed. Mar. 5, 2008) (statement of Rep. Deal).

334. *Id.* at H1297 (testimony of Representative Jim Ramstad of Minnesota).

be considered a trivial illness to some could be more severe to others. Furthermore, the MHPAEA does not only apply to “severe” or “serious” mental illnesses. It applies to all mental illnesses. It does not, though, remove medical necessity determinations from the hands of insurance providers. Therefore, by including the DSM, Congress could have insured that no mental illness would be automatically considered “unnecessary”; rather, insurance providers would be required to decide medical necessity on a case-by-case basis. The MHPA language won out, and group health plans that offer mental health and substance use coverage continue to determine which diseases or afflictions constitute mental illness.

Another major flaw in the MHPA that continued through passage of the MHPAEA is the law’s failure to *mandate* coverage of mental illness and substance abuse.<sup>335</sup> The language of the MHPA – “[n]othing in this section shall be construed as requiring a group health plan . . . to provide any mental health benefits” – remains.<sup>336</sup> By enacting the MHPAEA, Congress garnered praise from the mental health community for finally enacting “full parity.”<sup>337</sup> What Congress actually enacted, however, is full parity *in benefits*. While it is difficult to settle on a single definition of “full parity,”<sup>338</sup> generally when one hears the phrase it is meant to describe benefits parity. The MHPAEA requires group health plan insurance providers that *offer* mental health benefits to offer them with no additional restrictions to those applied to medical and surgical benefits. Like the MHPA, though, the 2008 Act does not *require* any insurance plan to offer mental health benefits. That is, it does not *mandate* benefits. Some believe this is not an issue.<sup>339</sup> However, Webster’s defines parity as “the quality or condition of being equal or equivalent; a like state or degree.”<sup>340</sup> It is difficult to argue that

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323\*- MHPAEA, Pub. L. No. 110-343, §§ 512(a)(4), (b)(4), (c)(4) 122 Stat. 3881-89 (2008).

335. Both laws are drafted such that the parity requirements only apply “in the case of a group health plan . . . that provides both medical and surgical benefits and mental health benefits.” See 29 U.S.C. § 1185a(a)(1) (2000); see also MHPAEA §512(a)(1). Of course, the new law also applies to substance use disorder benefits, but that provision also only applies if the plan offers such benefits.

336. 29 U.S.C. § 1185a(b)(1) (2000).

337. See Guadagnino, *supra* note 275 (reporting that, while discussing the impact of the MHPAEA on New Jersey, the director of advocacy programs for the National Alliance of Mental Illness of New Jersey characterized the law as having “full parity”).

338. *But see* Levinson & Druss, *supra* note 5, at 143 (stating that “[f]ull parity refers to the equalizing of all treatment and dollar limits between medical and mental health care as well as the same co-payments and coinsurance rates”).

339. See, e.g., Guadagnino, *supra* note 275 (reporting that the director of advocacy programs for the National Alliance of Mental Illness of New Jersey does not believe that it is a concern that the federal government will not mandate the offering of mental health coverage).

340. Merriam-Webster’s Online, Parity, <http://www.merriam-webster.com/dictionary/parity> (last visited Sept. 11, 2010).

mental health benefits have the quality or condition of being equal or equivalent to medical and surgical benefits if insurance providers are permitted to refuse their coverage, even when fully covering more costly and less treatable conditions.

Even a small number of providers refusing to cover mental illnesses or substance use disorders will mean that some individuals affected by these diseases are not receiving proper treatment and assistance in order to fully participate in society. And again, this does not address the fact that some insurance providers completely dropped coverage following implementation of the MHPA.<sup>341</sup> It can be presumed that this figure will at least be duplicated, if not surpassed, upon implementation of the much stricter MHPAEA. No percentage of the mentally ill population should be left to fend for itself.

In order to ensure that all individuals suffering from mental illness are protected, the federal law should be amended to reflect the requirements of the FEHBP. Since January 1, 2001, that program has provided coverage for mental health and substance abuse on par with coverage for medical and surgical benefits.<sup>342</sup> On June 7, 1999, in the face of discriminatory coverage for federal employees suffering mental illness and acknowledging the MHPA's failure to end discrimination, President Clinton announced Executive Order 13,124, mandating parity benefits for federal employees.<sup>343</sup> Not only did the Office of Personnel Management require participating FEHBP plans to provide mental health coverage at parity with other benefits, it also required the plans to provide coverage for "all diagnostic categories of mental health and substance abuse conditions listed in the [DSM]."<sup>344</sup> One aspect of the MHPAEA that goes beyond what the FEHBP requires is out-of-network parity. While the FEHBP required both coverage and parity *in-network*, it did not require parity out-of-network.<sup>345</sup> However, in a study

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341. 2000 GAO REPORT, *supra* note 48, at 17.

342. See Darrel A. Regier et al., *Parity and the Use of Out-of-Network Mental Health Benefits in the FEHB Program*, HEALTH AFF. WEB EXCLUSIVE, Dec. 18, 2007, at w70, w72.

343. See Exec. Order No. 13,124, 3 C.F.R. 192 (1999), reprinted in 5 U.S.C. §3301 (2000); see also Remarks at the White House Conference on Mental Health, *supra* note 118, at 894. President Clinton stated that on that day, the Director of the Office of Personnel Management would "inform nearly 300 health plans across America that to participate in our program, they must provide equal coverage for mental and physical illnesses. With this single step, 9 million Americans will have health insurance that provides the same copayments for mental health conditions as for any other health condition, the same access to specialists, the same coverage for medication, the same coverage for outpatient care." *Id.* at 896.

344. See Janice R. Lachance, *Memorandum for Personnel Directors of Executive Departments and Agencies: Mental Health and Substance Abuse Parity Implementation in the Federal Employees Health Benefits (FEHB) Program* (July 13, 2000), at [http://www.opm.gov/insure/health/parity/071300\\_mental\\_health.htm](http://www.opm.gov/insure/health/parity/071300_mental_health.htm).

345. Regier et al., *supra* note 342, at w72-73.

of the FEHBP from 2001-2007, it was determined that combined costs did not rise in response to managed in-network parity and out-of-network nonparity.<sup>346</sup> While the FEHBP does not constitute complete parity, as it does not require out-of-network parity, it is the closest attempt yet. After seven years, it shows that parity coverage can be mandated and still be affordable.

Advocates are fully aware of the historical discrimination against this group.<sup>347</sup> They should not settle for overlooking a small percentage of this population that will remain uncovered because of the lack of a mandate. It appears that certain health benefit plans simply will not offer coverage for mental health benefits, no matter the evidence in support of such coverage, without legislation requiring that they cover it. It seems that the term mandate causes some fear. However, the MHPAEA does not mandate any company or group health plan to offer insurance at all. These businesses and providers choose to insure their employees or plan subscribers. The federal law should mandate that they do so in a non-discriminatory manner.

Other issues remain, including failure of the MHPAEA to apply to individual health insurance plans or to Medicare or Medicaid. However, it seems that the law with regard to group health plans alone still has steps to overcome. A cost exemption still permits group health plans to forgo parity requirements in the face of minimal cost increases, and the federal law still allows "small employers" freely to offer disparate coverage. Furthermore, continuing to allow insurance plans to define mental illness, instead of relying on the DSM, opens the door to potential discrimination against certain illnesses and treatments that providers determine are too costly or not sufficiently effective.

#### CONCLUSION

After decades of discrimination against the mentally ill in this county, many might argue the MHPAEA represented the first piece of meaningful parity legislation ever passed by the federal government. Due to fear of cost-prohibitive increases in premiums and plan expenses, it took several years and many compromises for Congress to enact the MHPA in 1996; and while the law was praised, it fell flat when insurance providers used its exceptions to continue discrimination. Furthermore, the law failed in any way to protect individuals suffering from substance use disorders, although evidence shows that many of these sufferers are so plagued as a result of their mental illness. Almost every state tried its hand at enacting a parity law of its own, but federal preemption rules meant that most of these laws would

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346. *Id.* at w80.

347. See *supra* section I (discussing the historical discrimination against the mentally ill).

not reach many targeted insurance plans. After twelve years of battling the less and less credible cost argument, Congress enacted the MHPAEA, requiring full parity for mental health benefits when providers offer such coverage. The new law has addressed many of the flaws of the MHPA, and hopefully will achieve its goal of providing equitable coverage to the millions of individuals who have yet to receive it. But it fails to mandate coverage, and it leaves in place some debatable exemptions from the MHPA. Only time will tell whether the MHPAEA's failure to address fully the flaws of the past will cause continued discrimination against the mentally ill.

JUSTIN C. WILSON\*

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