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Achieving Parity of Coverage Between Mental and Physical Health Care

Erica A. Fishel

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I. INTRODUCTION

Issues of mental illness affect over fifty million Americans.[1] Despite the prevalence of mental illness in our society, sufficient coverage of and access to mental health treatment remains an issue.[2] Over the past quarter century, federal and states laws have been passed to effectuate change in the availability and accessibility of mental health care services.[3] Disparity between coverage of metal health benefits and physical health benefits nonetheless persists.[4]

Mental illness and serious mental illness affects approximately one in five Americans, yet more than a quarter of people reporting mental illness perceived an unmet need for mental health services in 2019.[5] While a number of reasons potentially account for why an individual might perceive themselves as having an unmet need for mental health services, the primary reason individuals reported such an unmet need was the inability to afford the cost of care[6] followed closely by not being aware of where to go to access services.[7]

Alone, these data illustrate that millions of Americans are unable to access vital mental health services and indicate a need for improved parity laws to ensure mental health care coverage and access for Americans.[8] The need for critical coverage and access to mental health

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[1] SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2019 NATIONAL SURVEY ON DRUG USE AND HEALTH, HHS Publication No. PEP20-07-01-001 (2020) [hereinafter 2019 SAMHSA SURVEY].
[2] *Id.*
[3] Kelsey N. Berry *et al.*, *Litigation Provides Clues to Ongoing Challenges in Implementing Insurance Parity*, 42 J. HEALTH POLITICS, POLICY & LAW 1065, 1098 (2017).
[4] *Id.*
[5] *See* 2019 SAMHSA SURVEY, *supra* note 1.
[6] *Id.* (Table 8.34B shows that 43.9 percent of adults with any mental illness listed could not afford cost as the reason they did not receive mental health services in 2019 and Table 8.35B shows that 51.8 percent of adults with serious mental illness reported that they did not receive mental health services because they could not afford the cost in 2019).
[7] *Id.* (Table 8.34B shows that 33.1 percent of adults with any mental illness listed did not know where to go for services as the reason they did not receive mental health services in 2019 and 36.8 percent of adults with serious mental illness reported that they did not receive mental health services because they did not know where to go for services in 2019).
[8] *Id.*

services, however, is far greater today with headlines underscoring the impact of the current COVID-19 pandemic on American mental health and well-being.[9] A heightened demand for mental health services is common in response to natural disasters, war, or epidemics.[10] The enduring and worldwide nature that the COVID-19 pandemic presents unique challenges to the demand for mental health services.[11] This is because COVID-19 is associated with mental health issues related to the mortality and morbidity of the disease.[12] Moreover, the percentage of Americans with recent symptoms of mental illness and the percentage of those reporting an unmet mental health care need have both increased during the COVID-19 pandemic.[13] As such, the need for health care insurance that covers treatments and services for both mental and physical health is increasingly more critical.

This paper demonstrates that there is an urgent need to adopt comprehensive federal legislation to address the ongoing disparities between physical health care coverage and mental health care coverage. It argues that the COVID-19 pandemic has cast a spotlight on the critical importance of mental health and highlighted such disparity.

This paper details the history of federal mental health parity law and examines different methodologies used to compare the mental health parity laws across states. Subsequent to the analysis of federal and state mental health parity laws, this paper provides an overview of the

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[9] *See, e.g.*, Ashley Kirzinger *et al.*, *KFF Health Tracking Poll-Early April 2020: The Impact of Coronavirus on Life in America*, KAISER FAMILY FOUND. (2020); s*ee also* Naomi M. Simon *et al.*, *Mental Health Disorders Related to COVID-19–Related Deaths*, 324 JAMA 1493, 1494 (2020).
[10] Danuta Wasserman *et al.*, *Adaptation of Evidence-Based Suicide Prevention Strategies During and After the COVID-19 Pandemic*, 19 WORLD PSYCH. 294 (2020).
[11] *Id.*
[12] Mark É. Czeisler *et al.*, *Mental Health, Substance Use, and Suicidal Ideation During The COVID-19 Pandemic—United States, June 24–30, 2020*, 69 MORB. MORTAL. WKLY REP. 32 (2020).
[13] Anjel Vahratian *et al.*, *Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic—United States, August 2020–February 2021*, 70 MORBIDITY AND MORTALITY WEEKLY REP. 3 (2021).

effects of the COVID-19 pandemic on mental health of Americans. The paper concludes by providing recommendations for a comprehensive federal mental health parity law with the objective of addressing the disparities in mental health care coverage to better ensure that Americans have essential access to general health care benefits to enhance their mental and physical wellbeing.

II. INITIAL HEALTH CARE COVERAGE IN THE UNITED STATES

Less than a century ago, Americans had little interest in health insurance.[14] However, after being hit hard by the Great Depression, hospitals were eager to find a path toward financial recovery and began embracing plans for prepaid health care.[15]

In 1929, Baylor Hospital formed the first group health plan when it agreed to provide approximately 1,500 teachers with inpatient care at its hospital.[16] Other employers and hospitals soon followed suit.[17] Limited in geographic scope, these early health insurance plans were means for hospitals and physicians to ensure that they were paid.[18] Such limitations also enabled these early health insurance plans to cover all employee health care costs which, in turn, encouraged employees to use medical care without worrying about out-of-pocket expenses.[19]

These initial hospital-sponsored employer plans became known as Blue Cross plans and were permitted by the state legislatures to operate as non-profit organizations.[20] By 1945, Blue

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[14] Linda Forman, *The History of Health Care Costs and Health Insurance*, 19 WIS. POL. RES. INST. REP. 10 (2006).
[15] *Id*.
[16] Peter Fox, *A History of Managed Health Care and Health Insurance in the United States*, ESSENTIALS OF MANAGED HEALTH CARE (2013).
[17] *Id*.
[18] *Id*.
[19] *Id*.
[20] *Id*.

Cross plans had captured more than half of the health insurance market.[21] Fueled by evidence-based research on the value of medicine conducted in the 1970s and 1980s, the popularity of managed health care was accompanied by the emergence of hundreds of group health plans.[22]

III. MENTAL HEALTH AND PHYSICAL HEALTH CARE PARITY LAWS

While the landscape surrounding mental health care coverage has changed over time, movement toward parity between health care coverage for mental health services and physical health services throughout the United States has been conducted in a piecemeal fashion.[23] Although Congress and each of the states has adopted one or more laws relating to mental health care parity,[24] the disjointed content and the fragmented timeframe of the adoption of federal and state parity laws has permitted disparity between mental health care coverage and physical health care coverage to persist.[25] Today, nearly a quarter of a century after the adoption of the first federal mental health parity law and underscored by the current COVID-19 pandemic,[26] there is an urgent need for the United States to adopt comprehensive federal legislation to address disparity in coverage of and access to general health care benefits.

A. Federal Parity Laws

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[21] Fox, *supra* note 16.
[22] James Robinson, *Consolidation and the Transformation of Competition in Health Insurance in the United States*, 23 HEALTH AFF. 6, 11-24 (2004).
[23] Berry, *supra* note 3.
[24] *National Statutory Landscape*, PARITYTRACK.ORG, https://www.paritytrack.org/reports/ (last accessed May 10, 2021).
[25] Berry, *supra* note 3.
[26] John Auerbach & Benjamin F. Miller, *COVID-19 Exposes the Cracks in Our Already Fragile Mental Health System*, 110 AM. J. PUB. HEALTH 969 (2020).

Mental health care coverage has historically lagged the coverage of physical health care conditions in the United States. Prior to enactment of mental health parity statutes, individuals suffering from mental illness turned to the courts when their health plans placed limits on the benefits covered for the treatment of mental illness, and the courts applied several approaches to determining whether an individual was subject to the limits of their health plan.[27]

For example, in *Ark. Blue Cross & Blue Shield, Inc. v. Doe*, a father of a woman being treated for her diagnosis of bipolar affective filed suit to recover benefits denied by his group health plan.[28] Ruling in favor of the father, the Court of Appeals of Arkansas based its holding on the on lower court's findings that, although the insurance policy provided liberal benefits for hospitalization and treatment of physical illness and limited coverage of expenses relating to metal health conditions, the insurance policy lacked definitions for either mental or psychiatric conditions.[29] As such, the court in *Ark. Blue Cross & Blue Shield* upheld the lower court's ruling that the father not be subject to the policy's limitations on mental health benefits based on expert testimony that established that the daughter's diagnosis of bipolar affective disorder constituted an illness of a physical nature.[30]

In *Kunin v. Benefit Tr. Life Ins. Co.*, a father sought recovery for medical expenses that he incurred for his son's treatment of autism after being died coverage for those expenses by his insurance provider.[31] Here, the United States Court of Appeals for the Ninth Circuit ruled in favor of the father, affirming the lower court's decision.[32] Reviewing the lower court's rationale,

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[27] *See, e.g.,* Ark. Blue Cross & Blue Shield, Inc. v. Doe, 733 S.W.2d 429 (Ark. 1987); Kunin v. Benefit Tr. Life Ins. Co., 910 F.2d 534 (9th Cir. 1990); Equitable Life Assurance Soc'y v. Berry, 260 Cal. Rptr. 819 (1989); Simons v. Blue Cross & Blue Shield, 536 N.Y.S.2d 431 (App. Div. 1st Dept. 1989).
[28] Ark. Blue Cross, 733 S.W.2d at 431.
[29] *Id.* at 430.
[30] *Id.* at 432.
[31] Kunin v. Benefit Tr. Life Ins. Co., 910 F.2d 534 (9th Cir. 1990).
[32] *Id.* at 535.

the *Kunin* court affirmed that the insurance policy at issue was ambiguous as to the term "mental illness" but declined to render a decision on the applicability of the lower court's arbitrary and capricious standard of review.[33] Instead, the court looked to expert testimony and lay person interpretation to affirm the lower court's decision that denial of benefits was improper because the son's diagnosis of autism was a physical condition and, as a result, the application of the plan's mental health policy limitations to deny coverage was not a reasonable interpretation of the policy.[34]

In contrast, in *Equitable Life Assurance Soc'y v. Berry*, the plaintiff brought suit to recover benefits after becoming disabled with a manic-depressive illness.[35] Affirming the lower court's decision, the Sixth Appellate District of the California Court of Appeal held that the insurance policy defined mental treatment in the policy and, moreover, that the policy stipulated against the payment of benefits for mental disorder treatments.[36] Using a layperson standard in reviewing the meaning and applicability of the insurance policy's limitations on metal health coverage benefits, the court in *Equitable Life Assurance* held that "every reasonable layman would view a person manifesting such derangements as suffering from a mental disease."[37]

In *Simons v. Blue Cross & Blue Shield*, the plaintiff brought suit to recover the unpaid balance of his daughter's hospitalization.[38] The appellate court held that the lower court had erred in denying the father's motion for summary judgment because there was a material factual disagreement between the parties, specifically, whether the treatment in question was medical or

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[33] *Id.* at 536.
[34] *Id.* at 536.
[35] Equitable Life Assurance Soc'y v. Berry, 260 Cal. Rptr. 819 (1989).
[36] *Id.* at 823.
[37] *Id.* at 824.
[38] Simons v. Blue Cross & Blue Shield, 536 N.Y.S.2d 431 (App. Div. 1st Dept. 1989).

psychiatric in nature.[39] The *Simons* court then applied a layperson standard to differentiate between medical and psychiatric therapy and held that there was no disagreement between the parties that the daughter's treatment was medical in nature, albeit for a psychiatric disorder.[40] Thus, the *Simons* court reversed the lower court's order and granted the father's motion for the recovery of unpaid hospital bills.[41]

The holdings by the courts in *Ark. Blue Cross & Blue Shield*, *Kunin* and *Equitable Life Assurance* illustrate the variable approaches different courts take in making determinations whether an individual suffers from a mental or physical illness and, therefore, whether that individual is entitled to coverage benefits for treatment that attends to that illness under a particular health policy. In response to this variability and, in an effort to increase access to mental health care coverage, Congress passed the Mental Health Parity Act (MHPA) in 1996.[42]

Although the MHPA required parity of aggregate lifetime limits and annual limits for group health plans that provided both medical/surgical benefits and mental health benefits,[43] the MHPA did not require group health plans to provide any mental health benefit. Additionally, the MHPA contained exceptions for small employers and businesses on the theory that those entities would incur an increased cost of at least one percent if they were required to comply with the law.[44] Perhaps most notably, the MHPA defined the term mental health benefits as relating to benefits with respect to mental health services but not with respect to substance use or chemical dependency treatment.[45] The law also failed to provide a definition for mental health.[46] In

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[39] *Id.* at 434.
[40] *Id.* at 434.
[41] *Id.* at 435.
[42] Mental Health Parity Act, Pub. L. 104-204, 110 Stat. 2874 (1996).
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] *Id.*

reaction to the requirements mandated by the MHPA, many group health plans introduced coverage limits to various treatments that they applied strategically to take full advantage of the statute's loopholes.[47]

Congress passed the Mental Health Parity and Addiction Equity Act ("MHPAEA") in 2008 to address several of the MHPA loopholes.[48] The MHPAEA prohibited group health plans that provided both medical/surgical benefits and mental health benefits from creating separate cost sharing requirements that were only applicable to mental health or substance use disorder benefits.[49] The MHPAEA also prohibited group health plans from creating separate treatment limitations that only apply to mental health or substance use disorder benefits.[50]

Unlike its predecessor the MHPA, the MHPAEA extended its requirements broadly and did not contain exceptions for small employers and businesses to mitigate any increased implementation costs.[51] Yet, just as the MHPA did not require group health plans to cover mental health services, the MHPAEA did not mandate the inclusion of benefits for mental health or substance use disorders across all group health plans.[52] As such, while the MHPAEA moved many group health care plans toward coverage parity between mental and physical health benefits, those health plans without any mental health care coverage remained unchanged.[53] Moreover, although that MHPAEA extended parity to both mental health and substance use

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[47] Amber Gayle Thalmayer *et al*., *The Mental Health Parity and Addiction Equity Act (MHPAEA) Evaluation Study: Impact on Quantitative Treatment Limits*, 68 PSYCH. SERVS. 435 (2017).
[48] Mental Health Parity and Addiction Equity Act, Pub. L. 110-343, 122 Stat. 3765 (2008).
[49] *Id*.
[50] *Id*.
[51] *Id*.
[52] *Id*.
[53] Berry, *supra* note 3.

disorders, the law failed to either define mental health treatment or characterize which conditions that term of art might include just as did the MHPA.[54]

In 2010, Congress again moved the needle toward establishing parity between metal and physical health coverage by enacting the Patient Protection and Affordable Care Act ("ACA").[55] Expanding the applicability of the MHPAEA, the ACA created federal and state-based health insurance exchanges and prohibited insurance coverage discrimination based on preexisting conditions.[56] Today, virtually all commercial health care plans fall under the auspices of the MHPAEA.[57]

The absence of comprehensive federal parity law disparity between mental health care coverage and physical health care coverage nonetheless endures due to subtle discriminatory practices by insurers and a lack of enforcement of federal and state laws.[58] For example, barriers to parity "include differences in how health plans enact utilization management and how they define medical necessity, separate deductibles and co-pays for mental and medical healthcare, limited behavioral healthcare services offered within their provider networks, and lower reimbursement for behavioral healthcare providers, to name a few."[59] Moreover, the impacts of such tactics on access to behavioral health treatment are significant. Behavioral health providers are reimbursed on average more than 20% less than primary care treatment providers.[60]

B. State Parity Laws

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[54] *Id*.
[55] Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).
[56] *Id*.
[57] Berry, *supra* note 3.
[58] Steven Ross Johnson, *Mental Health Party Remains a Challenge 10 Years After Landmark Law*, MODERN HEALTHCARE (Oct. 5, 2018).
[59] *Id*.
[60] *Id*.

Although much of the progress toward mental and physical health care coverage parity has occurred at the individual state level, differences in the focus, scope, standards, and other factors makes any meaningful comparison of state parity laws challenging.[61] Highlighting the difficulty of comparing health care coverage parity across the fifty states, two groups recently published methodologies to enable the measurement of the effectiveness of individual state mental health parity laws on achieving general health care parity.[62] Although the overall parity rankings between mental health care coverage and physical health care coverage of individual states were ranked dramatically differently between the two reports, both groups concluded that the combination of federal and state parity laws was insufficient to achieving parity in general health care coverage in any state in the country.[63]

In 2018, the Kennedy-Satcher Center for Mental Health Equity in the Satcher Health Leadership Institute at Morehouse School of Medicine and The Kennedy Forum developed a scoring method for evaluating mental health parity statutes.[64] Moreover, in 2019, Milliman released a report commissioned by the Mental Health Treatment and Research Institute that compared out-of-network use, reimbursement rates, and spending on mental health to assess the effects of federal and individual state parity laws on mental and physical health care coverage.[65]

The Kennedy Forum scored state parity laws and graded states using a set of questions that focused on whether the states' had enacted statutory language that mandated that mental health and substance use disorder services coverage be on the same terms and conditions as other

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[61] Berry, *supra* note 3.
[62] Ali Shana, *Mental Health Parity in the US: Have We Made Any Real Progress?*, 37 PSYCH. TIMES 30 (2020).
[63] *Compare* Megan Douglas *et al*., *Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report*, THE KENNEDY FORUM (2018) *with* Stoddard Davenport *et al*., *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, MILLIMAN RES. REP. (2019).
[64] Douglas *et al*., *supra* note 64.
[65] Davenport *et al*., *supra* note 64.

medical coverage; whether there were laws mandating that health insurance/benefit plans cover or offer to cover some or all mental health and substance use disorder treatment services; to which types of health insurance/benefit plans the relevant parity sections of state law apply; whether different types of plans were required to cover mental health and substance use disorder services in the same way; how mental health condition and/or substance use disorders were defined in state statutes; whether state statute expressly required coverage of outpatient visits, inpatient day, residential mental health or substance use disorder treatment, Medication Assisted Treatment, emergency medication without prior authorization; whether state statutes specified that non-quantitative treatment limitations, including, but not limited to, utilization review and prior authorization, must be comparable to—and applied no more stringently than—other medical care; whether state statutes required, authorized, or prevented the state insurance department or other relevant state agency from enforcing federal parity laws or from issuing regulations regarding federal parity law or any other relevant federal law; whether state statutes required the state insurance department or any other relevant state agency to submit reports about its actions monitoring parity compliance; and whether state statutes required health insurance/benefit plans to submit reports demonstrating how they comply with federal parity law and/or any state parity statutes or regulations.[66] Based on that comprehensive analysis, The Kennedy Forum ultimately determined that the states with the highest points and grades were Illinois, Tennessee, Maine, Alabama, Virginia, and New Hampshire.[67] The states to which the Forum assigned the lowest points and grades were Wyoming, Arizona, Idaho, Indiana, Alaska, and Nebraska.[68]

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[66] Douglas *et al*., *supra* note 64.
[67] *Id*.
[68] *Id*.

In contrast, the Milliman report assessed the rates of out-of-network utilization of inpatient facilities, outpatient facilities, and office visits to analyze parity between behavioral health care services and medical/surgical (physical health) care services.[69] While the Milliman report found overall disparity between behavioral health care services and physical health care services, it also concluded that it was possible to identify states where disparity existed between behavioral health care services and physical health care service by analyzing rates of out-of-network use of those relative treatment services. According to Milliman, the states with the greatest disparity between behavior health care services and physical health care services were Maine, Delaware, Washington, Connecticut, New Hampshire, and Pennsylvania.[70] Milliman further determined that the states with the least amount of disparity between such services were Arizona, Nevada, New York, Massachusetts, Alabama, and New Jersey.[71]

It further warrants mention that New Jersey, which was one of states that the Milliman report awarded a low disparity score, received an "F" score on mental health insurance coverage parity from a different national survey in 2018.[72] That survey, which was released by ParityTrack, gave New Jersey a score of 54 out of 100 possible parity points. The ParityTrack report "involved a systematic search of state statutes to identify how mental health diagnoses and [substance use disorders] are defined and used, how these laws govern insurance coverage, and how related laws and regulations are monitored and enforced."[73] New Jersey's poor performance in the ParityTrack report was primarily attributable to the state below-average

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[69] Davenport *et al*., *supra* note 64.
[70] *Id*.
[71] *Id*.
[72] Lilo H. Stainton, *NJ Gets Report Card "F" for Lack of Parity in Insurance Coverage of Mental Health*, NJ SPOTLIGHT NEWS (Oct. 5, 2018).
[73] *Id*.

insurance coverage rates for individuals who suffer from a mental health diagnosis. In New Jersey, for example one in nine diagnosed adults and one in twenty children with behavioral health issues lack health care insurance coverage, which falls well below the national averages in each of those categories (one in seven for diagnosed adults and one in thirteen for children nationwide).[74]

An alternative strategy for evaluating parity of health care coverage across the United States is through comparison of litigation brought under the MHPAEA and/or state parity laws because employing such a strategy underscores the importance of state parity laws over federal parity laws.[75] In a sample of thirty-seven cases from 2005 to 2015, twenty-six were brought under state parity laws alone while only seven cases were brought under the MHPAEA.[76] It is notable that the cases involving only state parity laws were clustered in just a handful of jurisdictions, including California, Washington, and New Jersey.[77]

This analysis highlights how parity regulates the coverage of conditions and their treatment in instances where the MHPAEA provides no regulatory oversight or potential relief.[78] For example, in *A.F. v. Providence Health Plan*, a patient was denied coverage for applied behavior analysis treatment for autism spectrum disorder on the basis of that "services 'related to developmental disability, developmental delays or learning disabilities' are specifically excluded from coverage."[79] The court held that the broad exclusion that the insurer used to deny the autism patient coverage of an accepted and medically necessary treatment violated the state's

[74] *Id*.
[75] Berry, *supra* note 3.
[76] *Id*.
[77] *Id*.
[78] *Id*.
[79] A.F. v. Providence Health Plan, 35 F. Supp. 3d 1298 (D. Or. 2014).

parity obligations.[80] Although the court found in favor of the patient in *A.F. v. Providence Health Plan*, it remains unknown whether another court would hold that an insurer's use of broad exclusionary criteria to deny standard of care treatment coverage violates the MHPAEA and/or other state parity laws. It also remains an open question whether another court would hold that the denial of a different treatment for a different mental health condition that fell within the criteria of for exclusion of a group health plan would violate parity obligations. Thus, here the interplay between federal and state mental health parity laws remains murky at best.

In *N.Y. State Psychiatric Ass'n v. UnitedHealth Grp.*, a plaintiff sued his health care provider for improperly administering coverage benefits by treating medical claims more favorably than mental health claims.[81] The individual patient plaintiff, who was joined in the suit by a professional organization of psychiatrists as well an individual psychiatrist, contended that the group health care plan violated MHPAEA parity by refusing to cover his medically necessary mental health care treatment.[82] The group health plan, UnitedHealth, moved to dismiss the amended complaint on the grounds that the psychiatrist organization did not have standing to sue on behalf of its members and the United States District Court for the Southern District of New York granted that motion. [83]

In rendering its decision, United States Court of Appeals for the Second Circuit held that the district court failed to consider whether the professional organization had pled facts sufficient to support a plausible claim of relief.[84] As such, the Second Circuit vacated the lower court's holding that the professional organization lacked standing and remanded the case to the district

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[80] *Id.* at 1302.
[81] N.Y. State Psychiatric Ass'n v. UnitedHealth Grp., 798 F.3d 125 (2d Cir. 2015).
[82] *Id.* at 128.
[83] *Id.* at 129.
[84] *Id.* at 131.

court.[85] The Second Circuit did, however, affirm the lower court's finding that the amended complaint including the individual psychiatrist's claims did not contain sufficient support for a claim of relief and that dismissal of the individual psychiatrist's claims therefore was not in error.[86]

More recently, however, mental health parity litigation has shifted from claims that sound solely under the MHPAEA and/or state parity laws to federal Employee Retirement Income Security Act ("ERISA") causes of action.[87] ERISA is a 1974 federal statute that regulates employee benefits and stipulates that a fiduciary "shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of . . . providing benefits to participants and their beneficiaries."[88]

For example, in *Wit v UBH*, a health insurance company denied coverage for a patient's stay at a residential treatment facility that specialized in treating women with eating disorders on the basis that the patient's "treatment does not meet the medical necessity criteria for residential mental health treatment per UBH Level of Care Guidelines for Residential Mental Health."[89] The United States District Court for the Northern District of California held that the health insurance companies' level of care guidelines were inconsistent with professional society guidelines, which reflected the accepted, applicable standards of care.[90] In that context, the court identified eight principles of accepted standards of care:

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[85] *Id.* at 131.
[86] *Id.* at 135.
[87] Paul S. Appelbaum & Joseph Parks, *Holding Insurers Accountable for Parity in Coverage of Mental Health Treatment*, 72 PSYCH. SERVS. 202 (2020).
[88] Employee Retirement Income Security Act, 29 U.S.C. § 1104(a).
[89] Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2020 U.S. Dist. LEXIS 205435 (N.D. Cal. Nov. 3, 2020).
[90] *Id.*

1. It is a generally accepted standard of care that effective treatment requires treatment of the individual's underlying condition and is not limited to alleviation of the individual's current symptoms;

2. It is a generally accepted standard of care that effective treatment requires treatment of co-occurring behavioral health disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders and conditions and their implications for determining the appropriate level of care;

3. It is a generally accepted standard of care that patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective – the fact that a lower level of care is less restrictive or intensive does not justify selecting that level if it is also expected to be less effective. Placement in a less restrictive environment is appropriate only if it is likely to be safe and just as effective as treatment at a higher level of care in addressing a patient's overall condition, including underlying and co-occurring conditions;

4. It is a generally accepted standard of care that when there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care;

5. It is a generally accepted standard of care that effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration;

6. It is a generally accepted standard of care that the appropriate duration of treatment for behavioral health disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment;

7. It is a generally accepted standard of care that the unique needs of children and adolescents must be taken into account when making level of care decisions involving their treatment for mental health or substance use disorders;

8. It is a generally accepted standard of care that the determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient.[91]

The decision in *Wit* triggered a ripple effect in mental health parity litigation to the extent that patients and providers began to contend that the delineation of principled standards for establishing standard of care in mental health treatment services may be based on professional

[91] Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2020 U.S. Dist. LEXIS 205435 (N.D. Cal. Nov. 3, 2020).

society guidelines.[92] However and just as with many of the other cases invoking combinations of MHPAEA and/or state parity laws, it remains unknown how other courts will apply the holding and rationale of *Wit.*

In sum, the application of MHPAEA, ACA, ERISA, and individual state parity laws have been unevenly enforced and interpreted and it remains difficult to predict when and how mental health parity laws might apply in individual cases.[93] Absent clarifying federal law and/or binding precedent, future claims litigation brought under the current patchwork of federal and state parity laws will undoubtably serve to further splinter an already complex landscape and likely hinder progress toward mental and physical health care coverage parity.

IV. IMPACT OF THE COVID-19 PANDEMIC

Provisional data from the Center of Disease Control demonstrates that COVID-19 was the third leading cause of death in the United States in 2020.[94] Previous large-scale epidemics, such as the Ebola virus disease epidemic provide insight on the effect of rapidly spreading diseases on mental health.[95] Approximately half of the Ebola virus survivors and their contacts reported enhanced mental health symptoms, including anxiety, posttraumatic stress disorder, and depression.[96] While grief and fear are common responses to natural disasters, war, and other infectious disease epidemics from which the potential impact of the current COVID-19 pandemic

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[92] Appelbaum & Parks, *supra* note 52.
[93] *Id.*
[94] Farida B. Ahmad *et al.*, *Provisional Mortality Data — United States, 2020*, 70 MORB. MORTAL. WKLY REP. 519, 519-22 (2021).
[95] Doron Amsalem *et al.*, *The Coronavirus Disease 2019 (COVID-19) Outbreak and Mental Health: Current Risks and Recommended Actions*, 78 JAMA PSYCH. 9, 9-10 (2021).
[96] *Id.*

may be evaluated, the unprecedented nature and scale of the COVID-19 pandemic situates the nation's escalating mental health crisis in a unique place in history.[97]

In fact, in June 2020, approximately one quarter of surveyed individuals reported symptoms of trauma or stress related disorder related to the pandemic.[98] Comparing prevalence of suicidal ideation, approximately twice as many respondents surveyed in 2020 reported serious consideration of suicide in the previous thirty days than respondents surveyed in 2019.[99] These increases in serious mental health issues illustrate an amplified need to address mental health parity in the United States.[100] Not only has COVID-19 wrought a disparate impact on mental health, such disparity disproportionally affects specific populations of Americans including young adults, Hispanic persons, black persons, essential workers, unpaid caregivers for adults, and those receiving treatment for preexisting psychiatric conditions.[101]

Illustrating the prolonged effect of the current COVID-19 pandemic, the percentage of adults reporting symptoms of an anxiety or a depressive disorder increased significantly from August 2020 to February 2021.[102] Over the period from January 20, 2021 to February 1, 2021, more than two in five adults reported experiencing symptoms of anxiety or depressive disorder over the prior seven days.[103] In addition, one in four of those who reported experiencing mental health-related symptoms also reported that they needed but did not receive counseling or therapy for their mental health.[104] Trends in symptoms of issues relating to mental health have been

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[97] *Id*.
[98] Czeisler *et al*., *supra* note 12.
[99] *Id*.
[100] *Id*.
[101] *Id*.
[102] Vahratian *et al*., *supra* note 13.
[103] *Id*.
[104] *Id*.

shown to be consistent with cases of COVID-19.[105] Given this understanding that increased prevalence of mental health issues and increased demand for mental health care services are common and predictable during and immediately following disruptive events such as natural disasters, war, or epidemics,[106] it is essential that the United States immediately tackle issues related to mental health parity in response to the current COVID-19 pandemic.

Furthermore, and illustrating at least a limited awareness concerning the dramatic impacts of the COVID-19 pandemic on mental health, Congress passed Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") in 2020, which, among other provisions, expanded support of Substance Abuse and Mental Health Service Administration programs.[107] In so doing, Congress poised the agency to effectuate positive change in the area of mental health care coverage.

In sum, the COVID-19 pandemic has, in many ways, drawn significant attention to the increasing disparity in mental health care coverage and underscored the necessity of addressing insurance coverage parity such that Americans have essential access to general health care benefits for both their mental and physical wellbeing.

V. COMPREHENSIVE FEDERAL PARITY LAW RECOMMENDATIONS

For the numerous reasons provided above, there is an urgent need to adopt comprehensive federal legislation to address the persistent disparity between mental and physical health care coverage in the United States. As discussed previously, the patchwork nature of federal and state parity laws has enabled disparity between coverage of mental health and

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[105] *Id.*
[106] Amsalem *et al.*, *supra* note 96.
[107] Coronavirus Aid, Relief, and Economic Security Act, Pub. L. 116-136, 134 Stat. 281 (2020).

physical health care to endure.[108] Specifically, Congress ought to pass a comprehensive federal law to address issues surrounding how mental health disorders are defined, how mental health disorder are covered, and how compliance with mental health parity law is enforced.[109]

A. Definitions

As explained above, "mental health" and "necessary mental health treatment" remain undefined by the MHPA,[110] the MHPAEA,[111] and the ACA.[112] As such, there is no federal definition for "mental health." As a result, Congress should enact a comprehensive federal parity law that provides a definition for mental health that is consistent with definitions used by medical mental health care professionals.[113] One possibility would be the adoption of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which is the handbook employed by psychiatric professionals in the diagnosis and treatment of mental disorders.[114] Alternatively, the implementation of the World Health Organization's International Classification of Diseases, which is used as a diagnostic tool for classifying and monitoring health and clinical practice across the globe.[115] That comprehensive federal parity law should also require that mental health disorders be treated as broad physical health conditions and evaluated on the basis of multidimensional assessments that take into account a wide variety of information about a patient.[116]

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[108] Berry, *supra* note 3.
[109] Douglas *et al*., *supra* note 64.
[110] Mental Health Parity Act, Pub. L. 104-204, 110 Stat. 2874 (1996).
[111] Mental Health Parity and Addiction Equity Act, Pub. L. 110-343, 122 Stat. 3765 (2008).
[112] Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).
[113] Douglas *et al*., *supra* note 64.
[114] *Id*.
[115] *Id*.
[116] *Id*.

In addition, and as noted in the holding of *Wit,* definitions of mental health should be careful to take into consideration the unique needs of children and adolescents regarding the level of care involving their treatment.[117] The involvement of professional organizations in the determination of medically necessary treatment was also developed in *N.Y. State Psychiatric Ass'n.*[118]

By relying on professional standard methods of diagnosis and classification and defining mental health disorders as physical health conditions, a new, comprehensive federal parity law would advance general health care coverage and work to achieve parity of metal health care coverage and physical health care coverage.

B. Coverage

A revised federal mental health parity law should include provisions that mandate that the determination of necessary medical treatment be based on medically acceptable standards.[119] It should include stipulations that conditions that share characteristics should be treated similarly with co-pays and out-of-pocket costs as general health care coverage costs and not allow for distinctions in these arenas between mental health care coverage cost and physical health care coverage costs.[120]

An effective federal parity law ought to require that the insurance benefit management process treat the individual's underlying condition as well as take into consideration the general

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[117] Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2020 U.S. Dist. LEXIS 205435 (N.D. Cal. Nov. 3, 2020).
[118] N.Y. State Psychiatric Ass'n v. UnitedHealth Grp., 798 F.3d 125 (2d Cir. 2015).
[119] Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2020 U.S. Dist. LEXIS 205435 (N.D. Cal. Nov. 3, 2020).
[120] Douglas *et al*., *supra* note 64.

health of the individual.[121] Comprehensive legislation should also include requirements that treatment limitations, specifically for quantitative treatment limitations and non-quantitative treatment limitations, are only permitted based on the standards of care determined by professional medical organizations in order to ensure parity of coverage between mental health care coverage and physical health care coverage.[122]

C. Enforcement

The piecemeal nature of our present federal and state parity laws has resulted in variations in the application of parity laws.[123] As noted previously, although the ACA brought the majority of health care plans under the MHPAEA, the lack of a comprehensive federal parity law has resulted the de facto exemption of certain health care plans from parity law coverage.[124] The fragmented nature of litigation brough under the various federal and state parity laws has served to further complicate issues of enforcement.[125]

As such, a new, comprehensive federal parity law must strengthen federal and state enforcement and compliance activities by empowering federal and state regulatory agencies to enforce parity laws. [126] Regular reports should be mandated and solicited by monitoring agencies to enforce compliance with parity laws.[127] Once all health plans are subsumed under federal parity law, federal parity law should mandate that group health plans submit regular analyses demonstrating compliance with relevant laws.[128]

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[121] *Id*.
[122] *Id*.
[123] *Id*.
[124] Berry, *supra* note 3.
[125] *Id*.
[126] Douglas *et al*., *supra* note 64.
[127] *Id*.
[128] *Id*.

VI. CONCLUSION

There is no doubt that effect of mental illness on Americans today is significant.[129] The current, unprecedented COVID-19 pandemic has augmented the need for access to and coverage of mental health care services.[130] In fact, the COVID-19 pandemic has highlighted the importance of addressing mental health care coverage in the United States.[131]

Although some progress has been made to achieve parity between coverage of mental health and physical health conditions over the past decade, much of that progress has been achieved through unstructured federal parity laws and inconsistent state mental health parity laws.[132] To effectively address disparity in coverage of and access to general health care benefits, it is paramount that Congress enact a comprehensive federal parity law encompassing all types of health insurance. Once a comprehensive federal parity law is in place, federal and state agencies must make every effort to enforce general health care coverage.

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[129] 2019 SAMHSA SURVEY, *supra* note 1.
[130] Amsalem *et al*., *supra* note 96.
[131] *Id*.
[132] Berry, *supra* note 3.