A Piecemeal, Step-by-Step Approach Toward Mental Health Parity

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Evolution in the field of mental health is a story of drastic paradigm shifts. Although mental illness has been present in society since ancient times, the road toward effective and humane treatments has been long and difficult. Before treatment efforts began, the mentally ill were locked away from the general public in asylums. Even after the focus turned from incarceration to treatment, for centuries, many of the methods—including therapeutic asylums, electroshock therapy, and lobotomies—were at best ineffective and at worst inhumane.

As a byproduct of some of the false starts and social isolation of past treatment efforts, those with mental illness have encountered discrimination in many facets of everyday life, including employment, access to housing, social interaction, and health care. The stigma associated with mental illness is deeply rooted in our culture and is

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1 Edward Shorter, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac 1-3 (John Wiley & Sons, Inc. 1997) (discussing treatment of mentally ill prior to advent of early asylums); id. at 33-65 (chronicling development and ultimate failure of asylums); id. at 69-109 (introducing nineteenth century origins of biological psychiatry); id. at 145-81 (describing psychoanalysis as a mere short-lived hiatus in larger context of psychiatry); id. at 239 (finalizing history of psychiatry by analyzing second rise of biological psychiatry in 1970s, its successes, shortfalls, and overuse).

2 See Shorter, supra note 1, at vii-viii. While physicians have studied mental illness since the time of the ancient Greeks, psychiatry as a discrete discipline did not emerge until the late eighteenth century. Id. at 1-15.

3 See Shorter, supra note 1, at 1-15 (discussing history of asylums for the mentally ill).

4 See Shorter, supra note 1, at 8-10, 33-34, 65-68, 218-29.

shared both by those who are afflicted with mental illness, as well as the population at large. The stigmatization reflects a failure to recognize the legitimacy of mental illness and significant advancements in its treatment.

Advances in mental health research have revealed that certain mental illnesses are biologically based; indeed, mental illness has consistently been linked to alterations in the structure, chemistry, and function of the brain. Despite the development of increasingly reliable methods of treatment, remnants of discrimination, particularly in the form of inadequate mental health care, have led to disparities in the availability of insurance coverage and treatment of mental illness. While the availability of insurance...
coverage for mental illnesses has significantly improved, substantial inequities remain. Part I of this Note will introduce the history and development of the movement toward parity in mental health, while paying close attention to the Mental Health Parity and Addiction Equity Act (“Equity Act”) and the Patient Protection and Affordable Care Act (“PPACA”). Part II will analyze the extent to which gaps in insurance coverage remain by examining the Equity Act and its interaction with state law. Part III will attempt to predict the impact of PPACA on mental health parity.

I. From Litigation to Legislation: The History of the Battle for Mental Health Parity

A. History of the Debate

The primary clinical tool for diagnosis and treatment of mental illness is the Diagnostic and Statistical Manual of Mental Disorders (“DSM”). The term “mental illness” refers broadly to all diagnosable mental disorders, including major depressive disorder, bipolar disorder, schizophrenia, obsessive-compulsive disorder, post-traumatic stress disorder, panic and anxiety disorders, autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder. The fields of psychiatry and...

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psychology have developed a broad range of treatments for these disorders, generally falling under the categories of psychosocial and pharmacological. Treatments for mental health conditions are, by and large, as effective as treatments for physical conditions.

Current estimates indicate that at least twenty-eight percent of the adult population is afflicted with a mental or addictive disorder, while the corresponding figure for the child and adolescent population stands at approximately twenty percent. Therefore, it is not surprising that mental illness is the leading cause of disability in the United States. Despite the prevalence of mental illness in the United States, there were no federal legislative efforts to achieve parity in mental health until the 1970s. And it was not until 1992 that major legislative efforts toward parity in mental health care gained headway in Congress.

In 1990, it cost the economy about seventy-nine billion dollars annually. The sources of these massive economic costs were lost productivity, premature death, and incarcerations—all attributable to mental illness. Psychosocial treatments include psychotherapy, psychodynamic therapy, behavior therapy, and humanistic therapy. Pharmacological therapy generally involves medication designed to alter the brain’s neurotransmitters with the goal of correcting biochemical abnormalities that typically accompany mental disorders.

See SURGEON GENERAL’S REPORT ch. 2, supra note 11, at 46. Notably, estimates regarding the percentage of the population suffering from mental illness vary based on the scope of the definition utilized. For example, an estimate from a mid-twentieth century study concluded that greater than eighty percent of the population exhibited symptoms of mental distress. In contrast, more recent studies, reflecting narrower mental illness definitions, indicate lower incidence rates.

See Kaplan, supra note 11, at 327 (noting mental disorders represent four out of ten leading causes of disability).

SURGEON’S GENERAL’S REPORT ch. 6, supra note 9, at 427.

See 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, 770-73 (1997-1998) (noting lack of congressional recognition of mental health parity issue until 1990s). Mental health parity legislation was introduced alongside President Clinton’s health care reform initiative in 1993. 

The mental health and substance abuse benefits in the Clinton bill are
The rise of the debate over mental health parity is tied to the rise of managed care. Over the course of seventeen years, from 1969 to 1986, the costs of inpatient psychiatric care rose dramatically, from three billion to approximately twenty-one billion dollars. The rise of health care costs led to a push by consumers, insurers, and the government toward managed care, predominantly due to its cost-reducing potential. After the shift to managed care, mental health care and medical health care were initially attainable at relative equality. As the costs of care rose, however, managed care organizations employed a number of practices to limit access to comprehensive mental health care. Methods by which access to coverage was, and may currently be, limited under a managed care structure include increased deductibles, reduced maximum

important ... by virtue of the fact that they are included ... [b]ut old data and old ideas keep us from covering mental health and substance abuse care just the same as we would cover heart disease or diabetes or other real illness ... [t]here should not be separate limits on days of care, or separate 50% co-payments on outpatient and community-based care, and additional deductibles for inpatient care. These features serve only to delay or deny the care many people need, and ... are intensely discriminatory.

Id.

18 Kaplan, supra note 11, at 328. The antecedents of the modern managed care structure are in century old health programs where companies contracted directly with physicians to provide low cost care for their employees. David Mechanic, The Rise and Fall of Managed Care, 45 J. OF HEALTH & SOC. BEHAV. 76, 78 (2004). The combination of research indicating that group practice resulted in high quality and low cost care, as well as increasing medical costs led to almost seventy percent of the country being enrolled in a managed care plan by the mid-1990s. Id. at 78-79. By fiscal year 2009, nearly ninety percent of the United States population was enrolled in some form of group plan, either employer or government sponsored. See CARMEN DE NAVAS-WALT, ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, 22, 24 (2010), available at http://www.census.gov/prod/2010pubs/p60-238.pdf (providing managed care statistics).

19 Kathleen D. Kennedy, Attacking ERISA Preemption: Not the Effective Prescription for Mental Health Care, 1 HOUSS. J. OF HEALTH L. & POL'Y 189, 197 (2001). The cause of the drastic rise of inpatient psychiatric costs during this period was the prevalence of the traditional fee-for-service payment structure, which did not provide an incentive to health care providers to contain costs. See id.

20 Id. at 197. Managed care organizations have approached cost containment in a number of ways, including limiting coverage for mental health services, monitoring health care providers to insure that services provided are appropriate and necessary, reducing the coverage of high-cost cases, and altering the reimbursement method so as to transfer financial risk to providers. Id. at 197-98.

21 See id. Contributing to plan managers dropping mental health from the scope of coverage was the increasing cost of mental, as opposed to medical and surgical, health insurance at the time. Id.
inpatient days and outpatient visits covered annually, and decreased lifetime and annual limits.\footnote{Kaplan, supra note 11, at 328. Often, under a managed care structure, an insurance plan will impose limits on the number of appointments with practitioners that the policy covers. See id. A lifetime limit is a cap on the benefits that an insurer will pay out over the life of the policy. See Definitions of Health Insurance Terms 4, http://www.bls.gov/ncs/ebs/sp/healthterms.pdf (last visited Apr. 13, 2011). An annual limit is a cap on the benefits that an insurer will pay out over a single policy year. Id. In insurance terminology, a deductible is the amount an individual must pay out of pocket for benefits before her insurance company begins paying for any of the costs of care. Id. at 1.}

The passage of the Equity Act, which resulted from legislators’ and activists’ efforts to curb managed care organizations’ aforementioned cost saving mental health care practices, undoubtedly marked a monumental advance in the field of mental health parity. In fact, the Equity Act has effectively remedied many discriminatory practices that were legal as recently as 2009. Nonetheless, and notwithstanding the Equity Act’s impact that will be discussed \textit{infra}, significant inequities remain in the field of mental health insurance. Moreover, despite the prevalence of mental illness, federal legislation does not currently require that health insurers offer mental health benefits.\footnote{See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a(b) [hereinafter “Equity Act”]. The act states, “Nothing in this section shall be construed—(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health or substance use disorder benefits.” Id.}

Accordingly, for many individuals, discriminatory coverage of mental health treatment persists despite recent federal efforts to improve mental health parity. For example, under some insurance plans, insurers are permitted to impose disparate limitations on the number of inpatient or outpatient sessions for mental illnesses that are not imposed upon other services.\footnote{See infra notes 57-58 and accompanying text (setting forth the Equity Act exemptions).} Generally, exceeding this limitation leaves individuals with two unattractive options: foregoing further treatment or paying sometimes exorbitantly high treatment costs out of pocket.\footnote{See Barrett, supra note 7, at 1160 (describing one family’s choice of paying over $130,000 for mental health costs out of pocket when insurance stopped covering treatment).}
B. Pre-Mental Health Care Legislation: Appeals to the Justice System

Before the rise of mental health parity statutes, those seeking equitable mental health benefits turned to the courts, and critically, the courts diverged in their approach to this issue.\(^26\) Claims challenging the scope of health care policies were more likely to be successful when the court classified a condition as a physical impairment, as opposed to a mental impairment.\(^27\) In contrast, when courts focused on the biological origins of a disorder, as opposed to its symptoms, they were more likely to classify a disorder as mental and find in favor of the defendant insurer.\(^28\) Alternatively, some courts have applied the doctrine of \textit{contra proferentem}—a basic tenet of contract law—to interpret ambiguous insurance policies in favor of those seeking insurance coverage for mental illness, and thus, construing ambiguities against the author of the policy.\(^29\) For the most part, however, claims challenging the legality of limitations on mental health coverage have been met with different results depending on the jurisdictional approach to mental


\(^{27}\) See Barrett, supra note 7, at 1172. For example, in \textit{Ark. Blue Cross and Blue Shield, Inc. v. Doe}, an insurance policy provided generous benefits for physical conditions but severely limited the available benefits for mental conditions. 733 S.W.2d at 430-31. Because the policy did not define what constituted a mental condition, the issue before the court was whether bipolar disorder was a mental or physical condition. \textit{Id.} at 432. The court recognized that the classification of bipolar disorder as a mental condition relied on an outdated symptoms-based classification method. \textit{See id.} at 431-32. Accordingly, the court ruled in favor of the insured, holding bipolar disorder to be a physical condition. \textit{Id.} at 432.

\(^{28}\) Compare \textit{id.}, with Stauch, 24 F.3d at 1054-56 (evaluating mental illness based on symptoms and ordinary meaning of term while discrediting relevance of its biologically based origin), and Brewer v. Lincoln Nat’l Life Ins. Co., 921 F.2d 150 (8th Cir. 1990) (declining to analyze scope of a policy’s mental illness coverage based on its biological origin but instead ruling in favor of insurer on basis of lay understanding of manifestations accompanying insured’s condition).

\(^{29}\) See, e.g., Phillips, 978 F.2d at 306-14 (applying the rule of \textit{contra proferentem} to interpret ambiguous policy term in favor of insured); Malerbi v. Cent. Reserve Life of N. Am. Ins. Co., 407 N.W.2d 157 (Neb. 1987) (interpreting ambiguous contractual term in favor of insured). \textit{Contra proferentum} means “against the offeror” and is defined as “the doctrine that, in interpreting documents, ambiguities are to be construed unfavorably to the drafter.” \textsc{Black’s Law Dictionary} 377 (9th ed. 2009).
C. The Mental Health Parity Movement: State and Federal Legislative Action

1. The Mental Health Parity Act of 1996: A False Start

In the spring of 1996, Senators Pete Domenici and Paul Wellstone sponsored a proposed amendment ("Wellstone Amendment"), which would have required full parity in mental health care, to pending health care legislation. Although the Senate unanimously approved the Wellstone Amendment, debates in the House of Representatives regarding the excessive costs of mental health parity resulted in the passage of the Mental Health Parity Act of 1996 ("MHPA"), a heavily compromised version of the originally proposed Wellstone Amendment. While the Wellstone

30 Gold, supra note 17, at 778-79. Not only have the results in this context been jurisdictionally dependent, but the benefit of even pro-parity rulings has been limited to individual plaintiffs because insurers have redrafted insurance policies to comply with such rulings. See Barrett, supra note 7, at 1173-74.

31 Health Insurance Reform Act of 1996, S. 1028, 104th Cong. § 305 (1996). The language of the Wellstone Amendment is illustrative of its comprehensive nature: "An employee health benefit plan, or a health plan issuer . . . shall not impose treatment limitations or financial requirements on the coverage of mental health services if similar limitations or requirements are not imposed on coverage for services for other conditions." Id. Unfortunately, the breadth of the proposed amendment, which would have broadly proscribed discriminatory practices in mental health care, in addition to accompanying cost concerns, is precisely what resulted in its failure. 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, 83 (1997).

32 Mental Health Parity Act of 1996, 29 U.S.C. § 1185a, amended by Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a; Gold, supra note 17, at 779-81. While the parity mandate of the Wellstone Amendment was laudable, even more significant was its exclusion of exemptions. See Health Insurance Reform Act of 1996, S. 1028, 104th Cong. § 305; see also infra notes 70-73 and accompanying text (defining parity mandate and explaining the importance of a comprehensive parity mandate in a mental health parity law). The bill that was ultimately passed, in contrast, contained much more restrictive language: "If the plan or coverage does not include an aggregate lifetime [or annual] limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime [or annual] limit on mental health benefits." 29 U.S.C. § 1185a(a)(1)-(2) (amended by Equity Act). Moreover, the MHPA contained several exemptions that limited its impact. See supra notes 25-28 and accompanying text. The debate that led to the compromised MHPA was centered around costs. Proponents of mental health parity argued that the costs of stepping mental health coverage up to the level of medical and surgical benefits would be minimal; according to a National Institute of Mental Health study, achieving parity would result in an overall cost increase of only 1.4 percent. Ruth L. Kirschstein, Nat'L Inst. of Mental
Amendment would have been a substantial step toward achieving parity, the agreed upon MHPA did little to advance the movement’s goals.\textsuperscript{33}

As such, the MHPA was a marginal improvement upon the parity landscape, in that it addressed only certain disparities in the insurance market.\textsuperscript{34} The area in which the MHPA made the greatest headway was in its parity benefit mandate, which prohibited insurers from imposing disparate annual and lifetime limits for mental health benefits as opposed to surgical and medical benefits.\textsuperscript{35} This parity mandate, however, was exceedingly narrow and left the door open for insurers to employ alternative mechanisms that discriminated against those in need of mental health benefits.\textsuperscript{36}

Aside from the minimal parity mandate, the scope of the MHPA was further

\textsuperscript{33} 29 U.S.C. § 1185a (amended by Equity Act). The minimal impact of the MHPA was retrospectively proven in an evaluation of the impacts of the MHPA on insurance practices and the accessibility of mental health benefits. See U.S. GEN. ACCOUNTING OFFICE, MENTAL HEALTH PARITY ACT: DESPITE NEW FEDERAL STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED 5 (2000), available at http://www.gao.gov/archive/2000/he00095.pdf [hereinafter U.S. GEN. ACCOUNTING OFFICE]. Even though as of 2000, eighty-six percent of employers were reportedly in compliance with the MHPA, whereas in 1996, prior to the MHPA’s passage, only fifty-five percent of employers reported providing parity in annual and lifetime benefit dollar limits. Id. at 11. Unfortunately, compliance with the MHPA proved to be ineffective at providing true parity in access to mental health benefits; ninety-three percent of employers that complied with the MHPA reported imposing some alternative feature applied more restrictively to mental health, as opposed to surgical benefits. See id. at 12 n.17. These features included lower outpatient office visit limits, reduced hospital day limits, and higher outpatient co-payments and co-insurance rates. Id. at 12.

\textsuperscript{34} 29 U.S.C. § 1185a (amended by Equity Act) (addressing various limits on benefits).

\textsuperscript{35} Id. § 1185a(a). The language of the MHPA demonstrates the extent of its parity mandate: “If the plan or coverage does not include an aggregate lifetime limit [or annual limit] on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit [or annual limit] on mental health benefits.” Id. The scope of a parity mandate is an essential element of a parity statute. See infra notes 62, 70-73.

\textsuperscript{36} See infra notes 62, 70-73. For example, the MHPA does not prevent insurers from covering a lower percentage of mental health care costs than medical and surgical health care costs. Gold, supra note 17, at 783. Alternatively, the MHPA does not prevent insurers from imposing higher coinsurance rates, dollar limits, or day restrictions upon mental health services. Id. While any of these mechanisms could potentially keep the cost of health insurance prohibitively high to be accessed by many, they would be permitted under the MHPA. 29 U.S.C. § 1185a (amended by Equity Act).
limited by generous exemptions and other restrictions. Included in the MHPA were two primary exemptions: one addressing small employers and the other protecting group health plans from cost increases. An additional failure of the MHPA was the absence of a specific definition of mental health; effectively, this authorized insurers to define the mental illnesses their policies would cover. Further minimizing the MHPA’s scope was the absence of any provision mandating consumer access to out-of-network mental health practitioners. Finally, the MHPA did not mandate that health insurance providers offer mental health coverage.

As expected, insurers took advantage of the gaping holes in the legislation, imposed discriminatory practices the MHPA did not proscribe, and avoided providing equal coverage. In fact, of those group health plans that reported compliance with the MHPA, eighty-seven percent contained some plan feature—such as limits on outpatient

37 29 U.S.C. § 1185a(c) (amended by Equity Act).
38 Id. (amended by Equity Act) One MHPA provision exempted small employers from its parity requirements:

This section shall not apply to any group health plan of a small employer . . .

the term ‘small employer’ means, in connection with a group health plan . . . an employer who employed an average of at least 2 but not more than 50 employees . . . during the previous calendar year.

Id. § 1185a(c)(1)(A)-(B) (amended by Equity Act). The other exemption, included to defray cost concerns, provided “[t]his section shall not apply with respect to a group health plan . . . if the application of this section to such plan . . . results in an increase in the cost under the plan of at least one percent.” See id. § 1185a(c)(2) (amended by Equity Act).
39 See id. § 1185a(e)(3)-(4) (amended by Equity Act). The MHPA defined mental health benefits as “benefits with respect to mental health services, as defined under the terms of the plan or coverage . . . but does not include benefits with respect to treatment of substance abuse or chemical dependency.” Id. § 1185(e)(4) (amended by Equity Act). In addition to the absence of a specific mental illness definition, this definition is notable for the explicit exclusion for substance abuse treatment coverage. 29 U.S.C. § 1185(e)(4) (amended by Equity Act) (defining substance abuse treatment coverage separately from mental health treatment coverage).
40 Id. § 1185a(a) (amended by the Equity Act); see also Richard A. Garcia, Equity for All?: Potential Impact of the Mental Health Parity and Addiction Act of 2008, 31 J. LEGAL MED. 137, 141-42 (2010) (noting no provision of MHPA requires insurers cover mental health services obtained from out-of-network provider, whether or not services could be obtained from such source for medical and surgical benefits).
41 Mental Health Parity Act of 1996, 29 U.S.C. § 1185a, amended by Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a. As a rule of construction, the MHPA makes it clear that “nothing in this section shall be construed . . . as requiring a group health plan . . . to provide any mental health benefits.” Id.
42 See U.S. GEN. ACCOUNTING OFFICE, supra note 33, at 5. But see infra notes 49-53 (setting forth the Equity Act provisions that remedy the MHPA’s shortcomings).
visits—that was more restrictive for mental health as opposed to medical and surgical benefits.\textsuperscript{43} Although the practical impact of the MHPA was limited by its exemptions and scope, retrospective data provided some hope for the future of the parity movement.\textsuperscript{44} For example, estimates regarding the increase in claims costs attributable to the MHPA were on average less than one percent.\textsuperscript{45} The modest cost increases that resulted from compliance with the MHPA provide an explanation as to why less than one percent of insurers dropped mental health benefits in reaction to the legislation.\textsuperscript{46}

2. \textit{The Mental Health Parity and Addiction Equity Act of 2008}

Despite the relative failure of the MHPA to provide substantive relief to those seeking equity in their search for mental health insurance, it was a long-awaited step

\textsuperscript{43}See \textit{infra} notes 49-53 (setting forth the Equity Act provisions that remedy the MHPA’s shortcomings).

\textsuperscript{44}See \textsc{U.S. General Accounting Office}, \textit{supra} note 33, at 5-6 (describing rate of compliance with MHPA and extent to which employers responded to MHPA by improving mental health benefits provided under group health plans).

\textsuperscript{45}Id. at 6. The cost increase predicted by actuarial studies evaluating the effects of full parity statutes providing for mental health and substance abuse benefits has been in the two to four percent range. \textit{Id.} at 17-18. Some tests, however, are more reliable than others; for example, prior to the passage of the MHPA, and in the absence of actual data regarding the cost effects of parity implementation, actuarial studies were heavily relied upon to determine the probable cost effectiveness. See Merrile Sing and Steven C. Hill, \textit{The Costs of Parity Mandates for Mental Health and Substance Abuse Insurance Benefits}, 52 \textsc{Psychiatric Services} 437, 437-39 (2001), available at http://psychservices.psychiatryonline.org/cgi/reprint/52/4/437. The sheer disparity among the actuarial cost increase predictions ranging from 3.2 percent to 8.7 percent displays the inherent limitation of actuarial studies. See \textit{id.} at 437. By contrast, the results of studies using a pre/post parity design typically have more reliable data upon which to rely, compared to actuarial analyses; such studies have commonly concluded that parity generally results in more modest cost fluctuations than actuarial studies predict, including cost decreases in some cases. See \textsc{Surgeon General’s Report} ch. 6, \textit{supra} note 33, at 427-28.

\textsuperscript{46}See \textsc{U.S. General Accounting Office}, \textit{supra} note 33, at 5-6. These results were in contrast to the expectations of many insurers and anti-parity activists; these individuals’ expectation was that the cost increases that the MHPA would cause would trigger employers to drop mental health benefits altogether. See Nancy Shute, \textit{Paying a High Price for Mental Health}, \textsc{U.S. News & World Report}, Oct. 25, 2007, http://health.usnews.com/articles/health/health-plans/2007/10/25/paying-a-high-price-for-mental-health.html (last visited Apr. 13, 2011). These results, however, may simply be attributable to the percentage of employers that were compliant with the requirements of the MHPA even before it was enacted. See \textsc{U.S. General Accounting Office}, \textit{supra} note 33, at 11. Indeed, considering the low parity requirements the MHPA imposed, as well as pre-MHPA employer compliance, the high post-MHPA compliance rate is unsurprising. See \textit{id.}
toward parity that provided a societal and legislative impetus for change.\(^{47}\) It was not until the passage of the Emergency Economic Stabilization Act of 2008, which also included the Equity Act, that the parity movement made further forward progress.\(^{48}\)

The Equity Act improves the mental health parity outlook by plugging some of the gaping holes in the MHPA.\(^{49}\) The most striking improvement of the Equity Act is its enhancement of the MHPA’s parity mandate. While the MHPA only mandated parity in lifetime and annual limits, the Equity Act broadly prohibits group health plans from imposing disparate financial or coverage restrictions on mental health care.\(^{50}\) Moreover, unlike the MHPA, the Equity Act requires that if a group health plan provides coverage for mental health or substance abuse services, it is commensurate to

\(^{47}\) See Barrett, supra note 7, at 1181 (detailing states’ legislative response to MHPA’s passage). The MHPA, even though not necessarily a significant step toward actual substantive parity, was nonetheless a positive advance for the movement. See Shannon, supra note 7, at 84-86, 105 (providing evidence of emotional importance of any legislative activity in favor of mental health parity). It would be unrealistic to expect to go from having no parity legislation whatsoever, to a fully comprehensive parity act. The failure of the Wellstone Amendment, which proposed full mental health parity, makes this point clear. Id. The very fact that some legislation was passed, however, not only minimally improved access to mental health services, but also brought attention to the debate over and fight for parity. See id.


\(^{49}\) 29 U.S.C. § 1185a(a)(1)-(3) (imposing broader financial parity requirements on insurers than MHPA); id. § 1185a(a)(5) (requiring insurers to cover out-of-network costs for mental health benefits if they do so for surgical and medical benefits); id. § 1185(c)(2) (narrowing cost exemption as compared to MHPA). But see id. § 1185a(c)(1) (maintaining same small employer exemption as MHPA); id. § 1185(a)(4) (leaving definition of mental illness to insurers).

\(^{50}\) 29 U.S.C. § 1185a(a)(3)(A). Specifically, the MHPA provides that

the financial requirements applicable to . . . mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan . . . and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits.

Id. § 1185a(a)(3)(A)(i).
the coverage provided for medical and surgical benefits. The scope of mental conditions qualifying for equal treatment is another example of the substantial extension of some of the MHPA’s provisions; the Equity Act specifically brings parity to substance use disorder benefits. Finally, the Equity Act requires parity in access to out-of-network providers of mental health benefits.

51 Id. § 1185a(a). In this respect, the Equity Act is much more comprehensive than the MHPA and represents a significant step toward parity. See id. The MHPA undoubtedly made possible restrictions through which group health plans could limit the accessibility of mental health care. See supra notes 36-41 and accompanying text. In contrast, the Equity Act goes to great lengths to ensure that discriminatory restrictions are not placed upon the accessibility of mental health care or substance abuse services. See 29 U.S.C. § 1185a(a). As a baseline requirement, the Equity Act forbids the imposition of more restrictive annual lifetime limits on mental health or substance abuse benefits. Id. In addition to repeating this requirement from the MHPA, however, the Equity Act goes on to impose further protections against group health plans’ discriminatory practices:

In the case of a group health plan . . . that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan . . . shall ensure that . . . the financial requirements [or treatment limitations] applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan . . . and there are no separate cost sharing requirements [or treatment limitations] that are applicable only with respect to mental health or substance use disorder benefits.

Id. § 1185a(a)(3)(A)(ii).

52 Id. § 1185a. Congress’ intent that the Equity Act apply to substance use disorders, as well as mental health benefits, is made clear by the repeated mention of both phrases in tandem throughout the Act. See, e.g., id. § 1185a(a)(1) (“In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits” (emphasis added). The Equity Act defines substance abuse disorder benefits as “benefits with respect to services for substance use disorders, as defined under the terms of the plan.” Id. § 1185a(e)(5).

According to the DSM, an individual is deemed to have a substance use disorder if at least one of the following four criteria is met: recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home; repeated substance use in a situation in which it is physically hazardous; regular substance-related legal problems; or continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. DSM-IV, supra note 10, at 199.

53 29 U.S.C. § 1185a(a)(5). The Equity Act specifies that:

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental
Despite the changes the Equity Act made, it represents only one step forward and still does not succeed in achieving true parity.\textsuperscript{54} Much like the MHPA, the Equity Act does not mandate that insurers provide mental health coverage.\textsuperscript{55} Moreover, similar to its predecessor, the Equity Act defers to insurance providers for definitions of mental health and substance use disorders.\textsuperscript{56} The Equity Act contains an exemption for small employers, who are not required to comply with its requirements.\textsuperscript{57} Additionally, the health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

\textit{Id.}  
\textsuperscript{54} See Garcia, supra note 40, at 143; Barrett, supra note 7, at 1180.  
\textsuperscript{55} Compare Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a(b)(1) (introducing MHPA’s rule of construction), with id. § 1185a(b) (setting forth Equity Act’s approach to same issue). The Equity Act clarifies that under no circumstances should it be interpreted to require group health plans to provide mental health or substance abuse benefits:  

\begin{quote}
Nothing in this section shall be construed . . . as requiring a group health plan . . . to provide any mental health or substance use disorder benefits . . . or in the case of a group health plan that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits.
\end{quote}

\textit{Id.} § 1185a(b).  
\textsuperscript{56} Id. § 1185a(e)(4)-(5). Specifically, sections 1185a(e)(4)-(5) provide that mental health and substance use disorder benefits are defined “under the terms of the plan and in accordance with applicable Federal and State law.” \textit{Id.} However, because the statutory definition of these terms is brief, the interdepartmental regulations promulgated pursuant to the Equity Act provide a marginally brighter picture, as well as further clarification:  

\begin{quote}
[P]lan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice . . . [t]his requirement is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements.
\end{quote}

\textsuperscript{57} 29 U.S.C. § 1185a(c)(1). A small employer is defined as one that had an average of between two and fifty employees in the previous calendar year. \textit{Id.} § 1185a(c)(1)(B). Given the context of economic turmoil in which the Equity Act was passed, however, and the high cost to small employers of providing health insurance, it is unsurprising that it contained this exemption. Garcia, supra note 40, at 143. As of 2004, small employers in the United States employed more than forty-five million individuals. Shail J. Butani et al., Business Employment Dynamics: Tabulations by Employer Size, \textit{BUREAU OF LABOR STATISTICS}, 21 (Dec. 2005), available at
Equity Act retains a cost exemption, which provides that insurers experiencing certain percentage increases in the costs of services as a result of applying the Equity Act will be exempt from its requirements.\(^5^8\)

3. State Parity Legislation

The prevalence of state parity legislation has increased dramatically in the past two decades.\(^5^9\) In fact, the parity statutes of the various states are in many cases more comprehensive than the Equity Act, often providing more significant mental health coverage than their federal counterpart.\(^6^0\) Two important factors that have contributed to the increase in state parity legislation are growing public support for parity legislation and the passage of the MHPA.\(^6^1\) The impact and effectiveness of any mental health


\(^5^8\) 29 U.S.C. § 1185a(c)(2)(A)-(B). That section reads:

If the application of . . . [the Equity Act] results in an increase . . . of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits by [two percent] of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year . . . .

\(^5^9\) See Barrett, supra note 7, at 1180-81. In the early nineties, prior to the MHPA's passage, only five states had mental health parity statutes on the books: Maine, Maryland, Minnesota, New Hampshire, and Rhode Island. Id. at 1181. In 1997, the year following the passage of the MHPA, thirty-four states introduced parity legislation. Id. Some form of each of those parity proposals was passed in eight of the states. See id. As of the year 2009, forty-six states had passed some form of parity legislation. See, e.g., ARK. CODE ANN. §§ 23-99-501 - 512 (West 2010) (setting forth Arkansas' parity statute, which is similar in form to Equity Act); D.C. CODE §§ 31-3101 - 3112 (2010) (codifying District of Columbia's parity statute, which mandates coverage of mental illness benefits); KY. REV. STAT. ANN. §§ 304.17A-660 - 669 (West 2010) (describing Kentucky's mental health parity requirements).

\(^6^0\) See, e.g., CONN. GEN. STAT. § 38a-488a (2010); VT. STAT. ANN. tit. 8, § 4089 (2010) (requiring group and individual insurance policies to provide equal coverage of mental health and substance abuse disorders).

\(^6^1\) Barrett, supra note 7, at 1181. More specifically, Elaine M. Hernandez has hypothesized that several factors influence the likelihood that a particular state will pass mental health parity legislation. See Elaine M. Hernandez, Sources of Variation in State Mental Health Parity Laws, UNIV. OF MINN., http://www.allacademic.com//meta/p_mla_apa_research_citation/1/0/4/2/8/pages104281/p104281-1.php (last visited Apr. 13, 2011). Hernandez cites political agendas, cost consciousness, and decreasing stigma as significant factors. Id. at 9. She further implies that the
parity legislation, however, is dependent upon four key elements: (1) the manner in which the statute defines mental illness; (2) the type of benefit mandate chosen; (3) the regulation of terms and conditions in insurance policies; and (4) the presence and scope of coverage exemptions. Because each state statute approaches these categories in a different fashion, the result is a high degree of variability in state parity legislation.

The role the definition of mental illness or disorder plays is one essential element of a parity statute’s efficacy, principally because the range of such a definition has the potential to either limit or broaden the scope of individuals who qualify for coverage. Generally, state parity legislation has used three different theoretical bases to define mental illness: (1) broad-based mental illness; (2) serious mental illness; or (3) biologically-based mental illness; collectively, these categories reflect the implicit value judgments as to which mental illnesses the state statutes will cover. Nevertheless, even

MHPA, as a major step toward decreasing the stigma surrounding mental illness, correlatively impacted the attitudes of individuals toward parity laws. See id. at 10.

See Barrett, supra note 7, at 1180-81. For example, Connecticut’s parity legislation, widely regarded as among the most comprehensive in the country, takes progressive approaches to each of these categories. See CONN. GEN. STAT. § 38a-514 (2010). Two notable features of Connecticut’s statute are references to the DSM for the definition of mental illness and a strong mental health benefit mandate. Id. §§ 38a-514, 553.

See Melissa M. McGow, Note, A Plan for Recovery: Steps to Finally Provide Adequate Insurance to Those Starving for it the Most, 15 ROGER WILLIAMS U. L. REV. 583, 603-04 (2010). Although most of the states have passed some form of mental health parity legislation, with respect to a condition such as anorexia nervosa, the mandated coverage varies significantly from state to state. Id. Indeed, looking at the coverage available for a specific condition on a state-by-state basis frequently renders disparate results. See id. For example, coverage for eating disorders such as anorexia nervosa is only available in roughly half of the states. Id. Coverage is available in states such as North Carolina and Illinois that specifically mandate coverage of eating disorders. Id. at 603-05. In states such as New Jersey, however, that mandate coverage of only biologically-based mental illnesses, a condition such as anorexia nervosa may not be covered. Id.

See Sara Nadim, Note, The 2008 Mental Health Parity and Addiction Equity Act: An Overview of the New Legislation and Why an Amendment Should be Passed to Specifically Define Mental Illness and Substance Abuse Disorders, 16 CONN. INS. L.J. 297, 309 (2009). According to Nadim, a state’s decision to define mental illness in a particular way tends to be the product of political and economic bargaining, as opposed to statistical, clinical, and medical factors. See id. Even so, there is not a clear consensus on the appropriate definition for mental health. See id. at 311-13. Two prominent advocacy groups, the National Association for the Mentally Ill and the National Mental Health Associations, have different criteria for defining mental illness. See id. at 312. The former uses a serious mental illness model while the latter addresses the issue based on an individual’s ability to function. Id.

Id. at 309. Each of these categories reflects not only a theoretical classification but also a value judgment as to which mental illnesses should have priority over others. See Nadim, supra note 64, at 312-13. Not only do most statutory schemes adopt one of these theoretical bases, but many
states adopting the same theoretical basis for defining mental illness have come to different conclusions regarding the particular conditions qualifying for coverage under that category, further suggesting the importance of precisely defining mental illness.66

For example, while all of the states using the biologically-based mental illness as the theoretical basis for a mental illness definition have included schizophrenia, major depressive disorder, obsessive-compulsive disorder, and bipolar disorder, only some have included autism, childhood depression, and post-traumatic stress disorder.67 Even more variation is found among the states that have adopted serious mental illness as the definition.68 Finally, the most inclusive definition, which is also the most likely to provide comprehensive coverage, is broad-based mental illness.69

specify the particular mental illnesses that they deem appropriate to fall within that definition. Id. 66 See Nadim, supra note 64, at 310. For example, both Massachusetts and New Jersey use a biological basis in defining mental illness. See MASS. GEN. LAWS ch. 32A, § 22 (2010); N.J. STAT. ANN. § 17:48-6v (West 2010). Massachusetts specifically lists eating disorders as a biologically-based mental illness that the statute covers. See MASS. GEN. LAWS ch. 32A, § 22(a)(10). In contrast, coverage of eating disorders is excluded from New Jersey’s list of biologically-based mental illnesses. See N.J. STAT. ANN. § 17:48-6v(a).

67 Nadim, supra note 64, at 310-11. This theoretical basis reflects the groundbreaking work of modern science through which substantial evidence has mounted showing the biological basis for several mental illnesses. See id. at 313-19. The biological foundations of mental illnesses have been linked to physical changes in the brain’s structure, chemistry, and function, as detected through magnetic resonance imaging. Id. at 314. Some of the mental illnesses that have been linked to such physical changes in the brain include schizophrenia, bipolar disorder, major depressive disorder, obsessive compulsive and panic disorders, posttraumatic stress disorder, autism, anorexia nervosa, and attention-deficit/hyperactive disorder. Id. at 315-19.

68 See Nadim, supra note 64, at 311. The reason for the variation among the states using “serious mental illness” is the absence of a common reference to any particular scientific basis. See id. at 311-12. A comparison of the California and Maine statutes, both of which use “serious mental illness” as a definition, is illustrative. Id. California’s statute only covers “schizophrenia, schizoaffective disorder, bipolar disorders and delusional depressions and pervasive developmental disorder.” CAL. INS. CODE § 10123.15 (West 2010). In contrast, Maine’s statute covers “[p]sychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse related disorders.” ME. REV. STAT. ANN. tit. 24-A, § 2843(5-C) (2010).

69 See Nadim, supra note 64, at 311-12. Broad-based mental illness is the broadest definition because it defines mental illness based on the DSM. Id. Because of the broad scope of conditions the DSM defines as mental illnesses, some statutes, such as that of Rhode Island, use the DSM as a starting point, and then name the DSM conditions not included within the scope of the statute. See R.I. GEN. LAWS § 27-38.2-2(2) (2010). Specifically, Rhode Island excludes “(i) mental retardation, (ii) learning disorders, (iii) motor skills disorders, and [iv] communication disorders.” Id. Similarly, the DSM was proposed as the basis for defining mental illness in the Equity Act. Nadim, supra note 64, at 312. However, because of the cost concerns of the
The second key element in assessing the comprehensiveness of a parity statute is its parity benefit mandate. In relation to mental health, the term benefit mandate refers to the circumstances and manner in which insurers are required to provide mental health services. A mandated benefit, the most comprehensive form of parity mandate, requires insurers to provide a minimum level of mental health services. In comparison, a mandated offering merely requires that insurers offer a plan that provides mental health benefits—typically at a higher price—but does not require that each plan the insurer offers provide mental health benefits. Finally, a mandated-if-offered structure, which is the least comprehensive benefit mandate, merely requires that if mental health services are offered, they are offered to the same extent as, and without greater financial restrictions than, medical and surgical benefits.

legislation’s opponents, getting the bill through the House of Representatives and the Senate necessitated leaving the definition of mental illness up to insurers to define. See id. at 311-12, 319-20.

70 See Kaplan, supra note 11, at 351-53.
71 See Kaplan, supra note 11, at 351. Among the states, the mandated benefit is the most prevalent form of benefit mandate. Id. Connecticut’s statute provides that “each group health insurance policy, providing coverage . . . shall provide benefits for the diagnosis and treatment of mental or nervous conditions.” CONN. GEN. STAT. § 38a-514(a) (2010). Even though the mandated benefit is the most comprehensive benefit mandate structure, a narrow mental illness definition or restrictive terms and conditions can severely mitigate its efficacy. See supra notes 49-54 and accompanying text. The minimum level of coverage is generally maintained by requiring insurers to provide the same level of coverage for mental health benefits as they provide for medical and surgical benefits. See, e.g., CAL. HEALTH & SAFETY CODE § 1374.72(a) (West 2010); CONN. GEN. STAT. § 38a-488a(b); MASS. GEN. LAWS ch. 32A, § 22(d), ch. 175, § 47B(d), ch. 176A, § 8A(d) (2010). Typical language requiring a minimum level of coverage, as Connecticut’s representative statute provides, states that, “No such policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions.” See CONN. GEN. STAT. § 38a-488a(b).

72 Kaplan, supra note 11, at 352. See, e.g., ALA. CODE § 27-54-3 (2010); GA. CODE ANN. § 33-24-28.1 (2010); MO. REV. STAT. § 376.1550 (2010). The language from Georgia’s mandated offering statute provides that, “[e]very insurer . . . shall be required to make available . . . either as a part of or as an optional endorsement to all . . . policies providing major medical insurance coverage . . . [and] coverage for the treatment of mental disorders.” GA. CODE ANN. § 33-24-28.1(b) (emphasis added). Although mandated offering states provide that each individual at least have access to mental health coverage commensurate to surgical and medical coverage, this coverage typically is more costly than the standard plan. Kaplan, supra note 11, at 351-52.

73 See Kaplan, supra note 11, at 352-53. Kentucky’s mandated-if-offered statute provides that “a health benefit plan . . . that provides coverage for treatment of a mental health condition shall provide coverage of any treatment for a mental health condition under the same terms or conditions as provided for treatment of a physical health condition.” KY. REV. STAT. ANN. §
The third element that typically defines the scope of a parity statute is the manner in which it regulates the specific terms and conditions of coverage. Some examples of terms and conditions that a mental health parity statute may regulate include co-payments, annual deductibles, out-of-pocket maximums, and inpatient and outpatient visitation maximums. The extent to which a statute requires that such provisions be provided at parity with surgical and medical benefits strongly influences the statute’s comprehensiveness.

Finally, the fourth key element of a parity statute is the extent to which it contains exemptions that limit the scope of its effectiveness. One of the most common exemptions allows statutorily defined small employers to provide employees with health insurance without complying with the parity statute’s provisions. The other exemption frequently provided for in parity legislation allows employers to avoid the provisions of the parity statute where previous compliance resulted in a cost increase exceeding a certain statutorily specified threshold.

Together, these four criteria establish the effectiveness of parity statutes, and as with the federal parity laws, many state mental health parity statutes contain gaps which thereby limit their efficacy.

304.17A-661(1) (West 2010). Additionally, the Equity Act is a mandated if offered statute. See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a(b) (clarifying that Equity Act does not require group health plans to offer mental health benefits but merely regulates group health plans that opt to do so).

Barrett, supra note 7, at 1181-83.

See, e.g., HAW. REV. STAT. § 431M-5 (2010) (requiring that deductibles and copayments for mental health services be no greater than those for physical illnesses).

Barrett, supra note 7, at 1181-83.

Barrett, supra note 7, at 1181-84. Because of the bipartisan nature of the political process, exemptions are typically necessary for the passage of a parity statute. Id. at 1184.


See, e.g., ARK. CODE ANN. § 23-99-505 (West 2010) (exempting plans from Arkansas’ parity statute where its application resulted in cost increase of greater than two percent in first year of application); IND. CODE § 27-8-5-15.7 (2010) (allowing exemption to plans that experience annual premium or rate increases of greater than four percent); TENN. CODE ANN. § 56-7-2360(d) (providing exemption in situations where application of mandate resulted in documented cost increase greater than one percent).
4. Federal Limits on State Parity Legislation

Despite the aforementioned statutory progress some states have made, the two most significant external limitations on the impact of state parity laws are the Employee Retirement Income Security Act of 1974 ("ERISA") and public insurance options. These limiting sources merit further discussion, but for the purposes of this Note, each will be briefly reviewed to the extent necessary to display their interaction with mental health parity laws.

ERISA limits the impact of state parity legislation by preempting any state regulation of self-insured health plans, but it does not preempt state laws that "regulate insurance." Generally, ERISA regulation is limited to substantive participation, funding, and vesting requirements of pension plans, as well as procedural reporting, disclosure, and fiduciary requirements for pension and welfare plans. In Metropolitan Life Ins. Co. v. Mass., the United States Supreme Court considered whether ERISA was intended to preempt mandated state benefit statutes as applied to employer-purchased health insurance policies. In applying traditional principles of statutory preemption, the Court concluded that mandated benefit statutes regulating the substance of employee health insurance plans “regulate insurance,” and thus were not preempted by ERISA. In contrast, the court concluded that ERISA does preempt state authority to

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80 Metro. Life Ins. Co. v. Mass., 471 U.S. 724, 733 (1985). As of the year 2010, approximately fifty-nine percent of the insured population obtained coverage through a fully or partially self-insured employee health plan. See Gary Claxton et al., KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 154 (2010), available at http://ehbs.kff.org/pdf/2010/8085.pdf. There are two self-insurance trends worth noting; first, the percentage of employees covered by self-insured plans has increased from forty-four percent in 1999, to fifty-nine percent in 2010; and second, there is a clear correlation between employer size and the likelihood of self-insurance. Id. at 155. For example, while only sixteen percent of employees of firms with between 3 and 199 workers were covered by a self-insured health plan, fifty-eight, eighty, and ninety-three percent of those employees employed by firms with between 200 and 999, 1000 and 4,999, and 5,000 and greater, respectively, were covered by a self-insured plan. Id.


83 Id. at 727. Metropolitan Life involved an action the Massachusetts Attorney General brought against Metropolitan Life Insurance Company, seeking to enforce Massachusetts’ mandated benefit statute. Id. at 727-32.

84 Id. at 747. The Court reasoned that the regulation of the substance of insurance has traditionally been preserved by the various states and that ERISA maintained this
regulate fully self-insured employee benefit plans. Accordingly, ERISA impacts state mental health parity laws because state parity statutes do not apply to self-funded insurance plans.

Similarly, state parity laws also do not apply to federally funded insurance offerings. As of 2009, approximately ninety-one million individuals obtained their health insurance through Medicare and Medicaid, the two largest federally funded health insurance programs. Because the states do not have the authority to regulate federally funded programs, changes in the federal arena must be reached through national mental health parity legislative efforts.

D. The Patient Protection and Affordable Care Act of 2010

1. Market Reforms

In March of 2010, under the leadership of President Barack Obama, Congress passed the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Affordability Reconciliation Act of 2010 (collectively “PPACA”), the most comprehensive health care reform legislation since the Medicare Act of 1965. The various provisions of PPACA will be periodically phased in until the year 2019.
One of the central provisions of the newly enacted health care reform law, which will increase access to health insurance, mandates that most Americans obtain health insurance. Beginning in 2014, individuals who fail to meet this requirement will be subject to penalties. It is estimated that the mandate will result in thirty-two million

Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 300gg-11) (prohibiting health insurance plans from setting lifetime limits or unreasonable annual limits); id. § 1001 (to be codified as amended at 42 U.S.C. § 300gg-12) (prohibiting rescissions); id. § 1001 (to be codified as amended at 42 U.S.C. § 300gg-14) (mandating insurers extend coverage to dependent children until age twenty-six). Many more changes will follow in 2014. See, e.g., id. § 1501(b) (to be codified as amended at 42 U.S.C. § 18091) (requiring most individuals to obtain minimum essential insurance coverage); id. § 1311(b) (to be codified as amended at 42 U.S.C. § 18031) (mandating each state to establish health benefit exchange); id. § 1201(a) (to be codified as amended at 42 U.S.C. § 300gg-3) (prohibiting insurers from imposing preexisting condition exclusions or discriminating based on health status); Patient Protection and Affordable Care Act of 2010, § 1201 (to be codified as amended at 42 U.S.C. §§ 300gg et seq.) (requiring all non-grandfathered plans offered through individual or small group market provide essential health benefits).

90 Id. § 1501(b) (to be codified as amended at 42 U.S.C. § 18091). Actually, PPACA only requires that “applicable individual[s]” obtain minimum essential coverage. Id. § 1501(d) (to be codified as amended at 26 U.S.C. § 5000A). Those who are exempt from the individual mandate are those who decline to obtain coverage for religious reasons, members of a Health Care Sharing Ministry, individuals who are not lawfully present in the country, and incarcerated individuals. Id. In response to PPACA’s individual mandate, some states have challenged its constitutionality. See Virginia v. Sebelius, 728 F. Supp. 2d 768, 770 (E.D. Va. 2010). In Sebelius, the court agreed with the Commonwealth of Virginia, ruling that the mandate oversteps the authority of Congress under the Commerce Clause and Necessary and Proper Clause. Id. at 788. In Florida ex rel. Bondi v. U.S. Dept. of Health and Human Services, the United States District Court for the Northern District of Florida took the ruling in Sebelius a step further. No. 3:10-cv-91-RV/EMT, 2011 WL 285683 at *39 (N.D.Fla., Jan. 31, 2011). The court not only found the individual mandate to be beyond Congress’ constitutional authority but also that the mandate was not severable from the remainder of PPACA. Id. Accordingly, the court declared PPACA as a whole to be untenable. Id. Notably, the court stopped short of enjoining PPACA’s enforcement. Id. In contrast, two district courts have ruled that the individual mandate is a constitutional exercise of Congress’ power under the Commerce Clause. Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882, 894-95 (E.D. Mich. 2010) (holding PPACA’s individual mandate was proper exercise of congressional power under Commerce Clause); Liberty Univ., Inc. v. Geithner, No. 6:10-cv-00015-nkm, 2010 WL 4860299, *14-*16 (W.D. Va. Nov. 30, 2010) (holding existing Commerce Clause jurisprudence justified PPACA’s individual mandate).

91 Patient Protection and Affordable Care Act of 2010 § 1501(c) (to be codified as amended at 26 U.S.C. § 5000A). Where an individual fails to obtain minimum essential coverage in any month starting after 2013, the penalty will be included with the taxpayer’s return for the taxable year that includes that month. Id. § 1501(b)(2) (to be codified as amended at 26 U.S.C. § 5000A). Generally, the amount of the formula will be the lesser of the average monthly premium for qualified health plans and the “applicable dollar amount,” which will be 95 dollars in 2014, 325
currently uninsured individuals obtaining health insurance by the year 2019.\textsuperscript{92} A study conducted in Massachusetts—a state imposing a similar individual health insurance mandate—displayed the positive impact that such a mandate can have on access to and use of health care.\textsuperscript{93}

In addition to the individual mandate, PPACA provides for another structural modification to the delivery of health care through the establishment of the health insurance exchange ("HIE").\textsuperscript{94} A HIE is conceived as a state-run entity that will regulate the quality, transparency, and substantive benefit offerings of qualified health insurance plans, while also providing a more competitive health insurance market.\textsuperscript{95} States will be required to set up HIEs by January 1, 2014.\textsuperscript{96}

dollars in 2015, and 695 dollars in 2016. Id. § 1501(c) (to be codified as amended at 26 U.S.C. § 5000A).


\textsuperscript{93}Sharon K. Long & Paul B. Masi, \textit{Access and Affordability: An Update on Health Reform in Massachusetts}, 28 \textit{Health Affairs} 578, 580 (2009), available at http://content.healthaffairs.org/content/28/4/w578.full.pdf+html. Long and Masi analyzed the impact of Massachusetts’ health reform, including its individual mandate, on access to health insurance in the key demographic of working age adults. \textit{See id.} at 578-79. The study initially notes that as of 2008, two years following the implementation of Massachusetts’ health care reform, the state’s rate of those uninsured was at 2.6 percent. \textit{Id.} at 578. The study compared a broad range of factors pertaining to patient access prior to and subsequent to health care reform. \textit{See id.} at 580. Results indicated that working age adults were more likely to have a regular place to go for health care, to have visited the doctor in the previous twelve months, and to have visited the doctor for purposes of preventive care. \textit{Id.} These increases in access were more pronounced for low-income adults. \textit{Id.}

\textsuperscript{94}Patient Protection and Affordable Care Act of 2010 § 1311(b) (to be codified as amended at 42 U.S.C. § 18031). Although states are not required to establish HIEs prior to 2014, PPACA provides the states with incentives to establish them earlier, rather than later. \textit{See id.} § 1311(a) (to be codified as amended at 42 U.S.C. § 18031). PPACA appropriates funding to assist the states in establishing exchanges, but the Act directs that no funding be disbursed for this purpose after 2014. \textit{Id.} § 1311(a)(4)(B) (to be codified as amended at 42 U.S.C. § 18031).


\textsuperscript{96}Patient Protection and Affordable Care Act of 2010 § 1311(b) (to be codified as amended at 42
Aside from the structural changes to the health insurance market that will be implemented through HIEs, PPACA provides for comprehensive regulation of the substantive benefits insurers provide. Once fully enacted, PPACA will require most insurance plans to offer essential health benefits, which include mental health, substance abuse, and behavioral health services. Only health insurance plans that offer essential health benefits will be qualified to offer plans through HIEs. Moreover, plans offered in the individual or small group market will be required to provide essential health benefits as well.

U.S.C. § 18031). If the circumstances indicate a state will fail to set up an appropriate exchange by the year 2014, the Secretary of the Department of Health and Human Services is directed to “establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.” Id. § 1321(c) (to be codified as amended at 42 U.S.C. § 18041).

Id. § 1302 (to be codified as amended at 42 U.S.C. § 18022). In addition to mental health, substance abuse, and behavioral health services, essential health benefits include “(A) Ambulatory patient services. (B) Emergency services. (C) Hospitalization. (D) Maternity and newborn care . . . (F) Prescription Drugs. (G) Rehabilitative and habilitative services . . . (H) Laboratory devices. (I) Preventive and wellness services . . . [and] (J) Pediatric services, including oral and vision care.” Id. § 1302(a)(1) (to be codified as amended at 42 U.S.C. § 18022). But see id. § 1251(a)(2) (to be codified as amended at 42 U.S.C. § 18011) (exempting grandfathered plans from providing essential health benefits).

See id. §§ 1301, 1311 (to be codified as amended at 42 U.S.C. §§ 18021, 18031). Specifically, section 1301 defines a qualified health plan as one that meets the criteria for certification, . . . provides . . . essential benefits, . . . is licensed and in good standing to offer health insurance coverage in each State … agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level . . . agrees to charge the same premium rate for each qualified health plan . . . without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer . . . complies with the regulations developed by the Secretary . . . and other regulations as an applicable Exchange may establish.

Patient Protection and Affordable Care Act of 2010 § 1301(a)(1) (to be codified as amended at 42 U.S.C. § 18022). Furthermore, section 1311 directs that only qualified health plans may be offered through HIEs. Id. § 1311 (to be codified as amended at 42 U.S.C. § 18031).

Id. § 1201(4) (to be codified as amended at 42 U.S.C. § 300gg-6). Section 1201 of PPACA amends the Public Health Service Act by providing that, “A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.” Id. This provision will have the effect of extending essential health benefits to a larger segment of the population than those who will obtain health
While PPACA does provide for many structural and substantive changes to health care, it also recognizes that many individuals are satisfied with their current insurance coverage. Accordingly, it grandfathers in certain health plans and allows those who are satisfied with the source through which they obtained coverage when PPACA was passed to maintain that coverage. Grandfathered plans will not be required to comply with many of PPACA’s reform provisions; thus, essential health benefits, such as mental health coverage, may not be provided through grandfathered plans.

While PPACA does not specifically describe the manner in which plans will lose care through a HIE. See id.; see also infra notes 185-187 and accompanying text (discussing the subset of the population that will qualify for coverage through a HIE). The small group market refers to the health insurance market, which provides coverage to individuals and their dependents who obtain insurance from a small employer maintained group health plan. Patient Protection and Affordable Care Act of 2010 § 1304(a)(3) (to be codified as amended at 42 U.S.C. § 18024). In contrast, the individual market is the source through which individuals obtain health insurance coverage not in connection with a group health plan. Id. § 1304(a)(2) (to be codified as amended at 42 U.S.C. § 18024). 

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1251, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 18011). PPACA states that “nothing in this Act . . . shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of enactment of this Act.” Id. § 1251(a)(1) (to be codified as amended at 42 U.S.C. § 18011). Not only does section 1251 allow individuals to retain whatever health plan that covered them on the day PPACA was passed, in certain situations it also allows family members and employees to join a grandfathered plan, also exempting them from many of the changes PPACA implemented. Id. § 1251(b)-(c) (to be codified as amended at 42 U.S.C. § 18011). Moreover, current enrollees are permitted to renew their coverage under a grandfathered plan. Id. § 1251(a)(2) (to be codified as amended at 42 U.S.C. § 18011). Section 1251 goes on to state that a grandfathered plan is any one that an individual was permitted to retain or permitted to join as a result of it being in existence on the day PPACA was enacted. Id. § 1251(e) (to be codified as amended at 42 U.S.C. § 18011).

Patient Protection and Affordable Care Act of 2010 § 1251(a)(2) (to be codified as amended at 42 U.S.C. § 18011). With a broad sweep, section 1251 exempts grandfathered plans from all of the provisions of subtitles A and C. Id. Notably, these portions contain many of PPACA’s substantive reforms. See id. §§ 1001-1004, 1201-1253 (to be codified as amended at 42 U.S.C. §§ 300gg-et seq.). Grandfathered plans will be forbidden from establishing lifetime limits or rescinding the coverage of enrolled individuals. Id. §§ 1001(a)(5), 1251(3)-(4) (to be codified as amended at 42 U.S.C. §§ 300gg-et seq., 42 U.S.C. § 18011). Moreover, grandfathered plans will be required to extend coverage to dependent adult children until the age of twenty-six. Id. In addition to the reform requirements applicable to all grandfathered plans, the Health Care and Education Reconciliation Act imposes another reform on grandfathered group health plans. Health Care and Education Reconciliation Act of 2010, Pub.L. 111-152, § 2301, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 18011). Such group health plans are forbidden from denying insurance on the basis of a preexisting condition. Id.
grandfathered status, the Interim Final Rules ("IFR") detail the actions taken by insurers that will result in grandfathered status forfeiture.\textsuperscript{103} The IFR, effective in most cases as of June 14, 2010, stipulate that health plans which eliminate diagnostic benefits, increase the insured’s percentage or fixed-amount of a cost-sharing requirement, or raise co-payments by an amount in excess of that the regulation’s formula provides will lose grandfathered status.\textsuperscript{104} Additionally, a group health plan that decreases its contribution rate or changes annual limits will lose its grandfathered status.\textsuperscript{105}

2. Improved Access, Quality, and Prevention

In addition to the PPACA provisions geared toward market reform that will functionally increase access to mental health care, the reform law calls for a reevaluation of the quality and effectiveness of the care that is delivered to consumers.\textsuperscript{106} One way in which PPACA seeks to achieve this goal is through a national strategy to evaluate treatment models and select those that are optimal based on results-oriented and evidence-supported frameworks.\textsuperscript{107} Historically, the mental health field has been resistant to the implementation of an evidence-based approach, even though adherence


\textsuperscript{104} Id.

\textsuperscript{105} Id.

\textsuperscript{106} Patient Protection and Affordable Care Act of 2010 §§ 3011-3015 (to be codified as amended at 42 U.S.C. § 280j) (providing national strategy for improvement of health care and various processes, mechanisms, and measurements for carrying out directive).

\textsuperscript{107} Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3011, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 280j). PPACA directs that the national strategy to improve the quality of health care, as one of its fundamental priorities, the improvement of health outcomes. Id. § 3011(a)(2)(B)(i) (to be codified as amended at 42 U.S.C. § 280j). In the context of the mental health field, an evidence-based approach is one that is based upon “consistent research evidence that is sufficiently specific to permit the assessment of the quality of the practices rendered as well as the outcomes.” Robert E. Drake et al., Implementing Evidence-Based Practices in Routine Mental Health Service Settings, 52 Psychiatric Services 179, 181 (2001), available at http://psychservices.psychiatryonline.org/cgi/reprint/52/2/179. Moreover, evidence-based practices are “interventions for which there is scientific evidence consistently showing that they improve client outcomes.” Id. at 179.
to such an approach has been generally effective. Despite the effectiveness of such treatment, however, policy debates persist in regard to the manner and extent to which an evidence-based approach ought to be implemented in the field of mental health.

As a byproduct of PPACA’s commitment to qualitative and quantitative improvements, substantial focus is placed upon providing preventive health services.

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108 See generally Surgeon General’s Report ch. 2, supra note 9. There are several reasons why there is a disparity between what research has proven to be effective models of treatment and the treatments that are actually implemented. Id. Among these explanations is that many practitioners are simply unaware of research results. Id. Additionally, at times there is significant delay between research results and their translation to practice. Id. Finally, the difference between research and practice settings explains the disparity. Id. at 72. The definition of an evidence-based approach is an intervention that scientific analysis has showed to result in improved patient outcomes. Drake, supra note 107, at 179. Drake observes that even though research has supported the implementation of evidence-based therapies, in many situations, they have not been implemented. Id. For example, despite advances in evidence-based schizophrenia research, many patients in state mental health systems were unlikely to reap the benefits of these research results. See generally Surgeon General’s Report ch. 6, supra note 9.

109 Sandra J. Tanenbaum, Evidence-Based Practice as Mental Health Policy: Three Controversies and a Caveat, 24 Health Affairs 163, 163 (2005), available at http://content.healthaffairs.org/content/24/1/163.full.pdf+html. The controversies in this area come in three forms: defining evidence, applying research in evidence, and determining what treatments are effective. Id. For example, although there is some consensus regarding the form of research methodology that ought to properly be considered to result in “evidence,” some criticize the hierarchy this approach creates. Id. at 164-66. There is an even more fundamental disagreement at the root of the debate over the value of applying research results to individual patients. Id. at 166-67. Even when research results are disseminated to practitioners, these results are often not applied to the treatment of patients. Id. This dynamic between researchers and practitioners is largely caused by the belief that even strict probabilistic research is not a substitute for the element of judgment that an experienced practitioner possesses. Id.

Health care reform stresses prevention by requiring insurers to provide services that the U.S. Preventive Service Task Force (“Task Force”) recommends. The Task Force has developed a comprehensive rating system ranking preventive services based on the certainty with which it can be determined that the service will provide a net benefit. One preventive strategy the Task Force recommended, and therefore PPACA mandated, is the integration of mental health and substance abuse care with primary care. While past efforts at integrating mental health and substance abuse care with

Preventive Services], Moreover, PPACA provides for the creation of the National Prevention, Health Promotion, and Public Health Council (“Council”). Patient Protection and Affordable Care Act of 2010 § 4001 (to be codified as amended at 42 U.S.C. § 300u-10). Among other duties, the Council will be charged with coordinating efforts of prevention, wellness, and integration at the federal level, while also making recommendations to the President regarding important health issues and updated evidence-based preventive models. Id. § 10401(a) (to be codified as amended at 42 U.S.C. § 300u-10).

111 Patient Protection and Affordable Care Act of 2010 § 4001 (to be codified as amended at 42 U.S.C. § 300u-10). To ensure that prevention efforts and programs remain up to date with current medical practices, PPACA provides for the establishment of a Prevention and Public Health Fund. Id. § 4002 (to be codified as amended at 42 U.S.C. § 300u-11). Among the substantive reforms for which insurers will have to provide without imposing any cost sharing or copayments include recommended immunizations. Id. § 2713(a)(2) (to be codified as amended at 42 U.S.C. § 300gg-13). PPACA also provides the states with grant-based incentives to ensure the delivery of recommended immunizations. Id. § 4204 (to be codified as amended at 29 U.S.C. § 794f). To prevent the epidemic of obesity and heart disease, PPACA further requires that restaurants with twenty or more locations provide consumers with information pertaining to its food’s nutrient content and recommended daily caloric intake. Id. § 4205 (to be codified as amended at 29 U.S.C. § 794f). As a protective measure against skin cancer, PPACA will impose a ten percent tax on the cost of indoor tanning. Id. § 10907 (to be codified as amended at 26 U.S.C. § 5000B).

112 Guide to Clinical Prevention Services, supra note 110, at 228-31. The Task Force provides recommendations as to which preventive services should be given priority and offered to men, women, pregnant women, and children. Id. at 3-7. In order to determine which services are appropriate, the Task Force assigns each a letter grade of A, B, C, D, or I, which denotes the relative certainty that the particular service will result in a net benefit. Id. at 228. Services receiving grades of A or B are recommended. Id.

113 See Guide to Clinical Prevention Services, supra note 110, at 131-47. The Task Force recommends the following forms of integration: primary care screening and behavioral counseling for alcohol misuse, screening for depression in adults, and screening for major depressive disorder children aged twelve to eighteen. See id. at 131-43. Alternatively, the Task Force concludes that “the evidence is insufficient to recommend for or against screening” as applies to screening adolescents for alcohol misuse or illicit drug use or screening children aged seven to eleven for major depressive disorder. Id. at 211. The integration of primary care and mental health care comes in many different forms, both in terms of the method of integration and the research that has been conducted to assess its effectiveness. Alexander Blount, Integrated Primary Care: Organizing the Evidence, 21 Families, Systems & Health 121, 121 (2003), available at
primary care have generally been successful in improving patient outcomes, the logistics of implementing integrative programs has at times been challenging.\footnote{Mary Butler et al., Integration of Mental Health/Substance Abuse and Primary Care 23-29, available at http://www.integratedprimarycare.com/Integration%20of%20Primary%20Care%20and%20MH-SA.pdf. In this meta-analysis, the effectiveness of integration of mental health specialists into primary care was evaluated primarily as applied to depression care, due to lacking data regarding integration outcomes for other mental health disorders. \textit{Id.} at 23-24. Integrative efforts on outcomes were evaluated based on severity of symptoms, remission rates, and treatment response rates. \textit{Id.} at 23. The study concluded that while the degree of integration did not have a significant impact on patient outcomes, the results of integrative efforts on the whole showed positive and significant impact on treatment response and remission rates. \textit{Id.} at 167.}

\section*{II. Interaction of State and Federal Law: The Current State of Mental Health Parity}

Spurred on by mental health advocacy groups, the proliferation of state parity initiatives has led to an overall increase in access to mental health coverage.\footnote{See supra note 59 and accompanying text (discussing rise of state parity legislation). Something of a chain reaction has resulted in this increased access. \textit{See} Barrett, supra note 7, at 1181. The first stage in the process was the recognition of the biological basis of mental illness, which reduced the associated stigma, and allowed individuals to feel more comfortable seeking out treatment for their mental illnesses. \textit{Id.} This decreased stigma surrounding and increased demand for mental health services resulted in substantial proliferation of parity legislation among the states. \textit{See id.; see also} Hernandez, supra note 61, at 9. In turn, the rise of parity legislation has made possible a correlative improvement in the accessibility of mental health coverage. \textit{See} Barrett, supra note 7, at 1181.} Not only are state parity statutes common but to the extent that they are applicable, they are generally more comprehensive than the federal Equity Act.\footnote{Nadim, supra note 64, 309-10. To prove the superior comprehensiveness of state laws, Nadim focuses on the manner in which mental illness is defined in various state statutes. \textit{See id.} at 309-13. For the most part, states provide specific definitions of the mental illnesses insurers must cover, as compared to the Equity Act, which leaves the definition of mental illness to the insurer. \textit{Compare} Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a(b), (e)(4) (deferring to insurance policies for the definition of mental health benefits), with CONN. GEN. STAT. § 38a-488a (2010) (using the DSM to set forth the benefits that must be covered) and N.J. STAT. ANN. § 17:48-6v (West 2010) (listing specific mental conditions that qualify as biologically based and for which coverage is mandated). Not only does most state parity legislation more broadly define mental illness, but the majority of states impose the most stringent form of benefit mandate—a mandated benefit. Kaplan, supra note 11, at 351. In contrast, the Equity Act only imposes a mandated if offered parity structure.}
areas, however, in which state parity laws are inapplicable, so the provisions of the Equity Act govern. Specifically, the Equity Act is the sole parity statute applicable to self-insured health plans and is also the sole statute applicable in jurisdictions where the Equity Act is more comprehensive than the state’s parity law.  

The prevalence of self-insurance and federally funded insurance poses a significant obstacle to the impact of state parity legislation. Even though the states’ parity efforts are in many cases quite comprehensive, ERISA preemption in the field of self-insured health plans vastly reduces the functional impact of state parity initiatives. Of the approximately 169 million individuals who obtained insurance through their employer in 2009, roughly ninety-six million obtained coverage through a self-insured health plan and thus, did not obtain the benefit of state parity legislation. Adding to the ineffectiveness of state parity laws is the extent to which Americans are insured through federally funded programs; the number of Americans obtaining coverage from this source was more than ninety-three million in 2009.

Further limiting the accessibility of mental health care is the failure of certain states to pass parity mandates that are more comprehensive than the Equity Act.

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29 U.S.C. § 1185(a)-(b).

117 See supra notes 80-87 and accompanying text (describing federal limitations on state parity law ERISA and federally funded health insurance programs impose); see also infra note 124 and accompanying text.

118 See supra note 80 and accompanying text (setting forth the percentage of the population that is insured under a self-insured health plan).

119 See generally supra notes 80-85 and accompanying text (discussing the mitigating effects of ERISA preemption on the efficacy of state parity legislation). Connecticut’s parity statute, for example, broadly defines mental illness and mandates that insurance providers offer benefits for diagnosis and treatment of mental illness at parity with medical and surgical benefits. See Conn. Gen. Stat. §§ 38a-488a(a), 38a-514(a) (2010).

120 See Denavas-Walt, supra note 18, at 22, 71; Claxton, supra note 80, at 155. The source of this figure is as follows: the census data provides that in 2009, 55.8 percent of the population of approximately 301 million, or roughly 168 million, had employment sponsored health insurance coverage. Denavas-Walt, supra note 18, at 22-23, 71. This figure was then multiplied by the percentage of employees covered by self-insured plans in 2009, which was fifty-seven percent, to reach the approximated figure of ninety-six million Americans covered by self-insured health plans. See Claxton, supra note 80, at 154. Notably, some of the ninety-six million with self-insured health plans will realize the benefit of more comprehensive state parity laws; the fifty-seven percent figure provided in Claxton includes both those plans that are fully self-insured and those that are partially self-insured. See id. ERISA, however, only preempts those state laws regulating fully self-insured plans. See Metro. Life Ins. Co. v. Mass., 471 U.S. 724, 747 (1985).

121 Denavas-Walt, supra note 18, at 71.

122 See Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and
Significantly, the Equity Act is federal legislation codified in ERISA, the Public Health Services Act, and the Internal Revenue Code, and is therefore applicable to both self-insured and fully insured health plans. As applied to fully insured health plans, however, the provisions of the Equity Act preempt only less comprehensive state legislation. Wherever a state’s parity law provides mental health care consumers with greater protection than the Equity Act, the state’s law is not preempted. Moreover, because of the structure and various limiting provisions of the Equity Act, its application in states with less comprehensive mental health parity statutes will result in inequitable coverage options for many of those in need of mental health treatment.

Despite the foregoing limitations on state parity statutes, they have the potential to serve as models for federal legislation and stimuli of social awareness. Unfortunately, history has shown Congress’ preference for incremental steps in the


124 Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. at 5430. The regulations provide that states are permitted to apply their parity laws unless they prevent the application of the Equity Act. Id. Therefore, state laws that are more comprehensive than the Equity Act are not preempted. Id. For example, Wyoming’s statute pertaining to mental illness, one of the least comprehensive of the states, merely provides that:

[N]o individual or group policy of accident or sickness insurance delivered or issued for delivery to any person in this state which provides coverage for mental illness or intellectual disability or both shall exclude benefits for the care or treatment of the mental illness or intellectual disability provided by a tax supported institution of the state.


126 See supra note 54 and accompanying text (detailing inherent limitations of Equity Act, including absence of mandated benefit parity mandate or clear definition of mental health and presence of robust exemptions).
127 See Hernandez, supra note 61. Just as the MHPA initially served as an impetus for the states to adopt parity initiatives, so too may the progress of the states toward parity spur Congress to adopt a more comprehensive parity law. See id.
legislative process, particularly in the field of mental health parity. In the past, parity initiatives at the federal level have proven effective in influencing states to mandate parity in mental health services to differing degrees. Although twelve years passed following the MHPA and leading up to the Equity Act, the public’s support for parity legislation was made clear by the spate of state parity legislation adopted following the MHPA. Insofar as stigmatization reflects a lack of understanding, the passage of state parity legislation may also serve as an impetus for promoting societal awareness and change.

Unfortunately, the Equity Act actually discourages insurers from offering mental health benefits. Notably, the Equity Act only requires those employers that choose to offer mental health benefits as a component of their insurance plans to offer it at parity. As a point of comparison, the MHPA’s mandated-if-offered parity benefit mandate did not cause employers to drop coverage of mental health benefits; indeed, only one percent of employers did so following the MHPA’s enactment. These

128 Compare Mental Health Parity Act of 1996, 29 U.S.C. § 1185a(a)(1)-(2), amended by Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a, with Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a(b). Prior to the passage of the Equity Act, the MHPA was the only substantial federal mental health parity legislation. The MHPA took only minimal steps toward achieving mental health parity and exemptions, a narrow mental health definition, ineffective parity provisions, and a mandated if offered benefit mandate largely limited its effectiveness. See supra notes 32-39 and accompanying text. The Equity Act, while a marginal improvement on the MHPA, retains many of its predecessor’s limitations, including a narrow mental health definition, generous exemptions, and a mandated if offered benefit mandate. See supra notes 53-58 and accompanying text.

129 See Barrett, supra note 7, at 1181. The only states to adopt parity prior to the MHPA’s enactment were Maine, Maryland, Minnesota, New Hampshire, and Rhode Island. Id. The year after the MHPA was passed, however, thirty-four states introduced parity legislation, which was passed in the same year in eight of those states. Id.

130 See Barrett, supra note 7, at 1181.

131 See Sadler, supra note 5, at 414-15.

132 See, e.g., Kaplan, supra note 11, at 340 (detailing quantity of insurers who dropped insurance coverage as result of implementation of Vermont’s parity statute); Barrett, supra note 7, at 1166-67 (citing statistical response of employers to passage of various parity mandates); Shannon, supra note 7, at 393-95 (setting forth various viewpoints on probable costs of parity initiative).


134 U.S. GEN. ACCOUNTING OFFICE, supra note 33, at 12. In response to the MHPA, less than one percent of employers surveyed reported dropping mental health benefits. Id. A pre-MHPA study that the Association of Private Pension and Welfare Plans conducted predicted that the total increase in costs attributable solely to covering serious mental illnesses would range from 8.4 to 11.4 percent. Shannon, supra note 7, at 392. The Congressional Budget Office similarly
results, however, can be attributed to the MHPA’s minimal parity mandate, to which nearly all employers responded by not providing true parity in mental health benefits.\textsuperscript{135} In contrast, the Equity Act imposes a much more comprehensive parity mandate on employers and eliminates the opportunities to circumvent parity available under the MHPA.\textsuperscript{136} Holding other variables equal, parity laws that impose more comprehensive parity mandates on insurers are likely to result in higher overall claims costs.\textsuperscript{137} Accordingly, the Equity Act’s more comprehensive parity mandate is likely to lead to higher claims costs than what occurred under the MHPA.\textsuperscript{138} To avoid such cost predicted billion dollar cost increases. \textit{Id.} at 393. Other national news publications predicted cost increases of up to ten percent. \textit{Id.} at 394. However, ninety-seven percent of responding employers indicated that they had not recognized an increase in claims subsequent to the MHPA’s passage. U.S. GEN. ACCOUNTING OFFICE, supra note 33, at 16. 

\textsuperscript{135} See U.S. GEN. ACCOUNTING OFFICE, supra note 33 at 17-18; see also supra note 21 and accompanying text (defining several health insurance plan features insurers use to control costs); supra note 36 and accompanying text (discussing manner in which group health plans responded to MHPA). While the costs increases resulting from the MHPA were less than one percent, the cost increases that can be expected as the result of a more comprehensive parity statute, such as one covering treatment for substance abuse and chemical dependency, or imposing a more comprehensive benefit mandate, could be substantially higher. \textit{See U.S. GEN. ACCOUNTING OFFICE, supra note 33, at 17-18; see also supra notes 45-46 and accompanying text (discussing variation and source of variation among studies predicting cost increases).} 

\textsuperscript{136} 29 U.S.C. § 1185a(a)(3)(A). Specifically, the Equity Act’s restriction of discriminatory pricing mechanisms and treatment limitations provides:

\begin{quote}
The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits, and the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.
\end{quote}

\textit{Id.} § 1185a(a)(3)(A)(i)-(ii).

\textsuperscript{137} U.S. GEN. ACCOUNTING OFFICE, supra note 33, at 17-18. For example, the MHPA only required parity in dollar amounts. \textit{Id.} Compelling insurers to provide mental health benefits at parity not only in dollar amounts, but also with regard to services limits and cost-sharing provisions, would result in higher claims costs. \textit{Id.} By the same reasoning, requiring insurers to provide substance abuse and behavioral health benefits at parity as well, would result in further claims cost increases. \textit{See id.}

\textsuperscript{138} U.S. GEN. ACCOUNTING OFFICE, supra note 33, at 17-18.
increases, some insurance plans have simply chosen to drop mental health coverage altogether and more may soon follow suit.\textsuperscript{139}

Even assuming the Equity Act does not prompt insurers of group health plans to rescind mental health coverage, the Equity Act’s small employer exemption will significantly limit the Act’s effectiveness.\textsuperscript{140} As of 2009, approximately 170 million individuals obtained insurance through an employment based insurance plan, making an employer the most likely source of health insurance.\textsuperscript{141} Furthermore, roughly forty-three percent of employees in the United States work for a small employer, which the Equity Act defines as one with less than fifty employees.\textsuperscript{142} Finally, in 2010, somewhere between forty-four and fifty-nine percent of employees of small firms were covered by a benefit plan their employer offered.\textsuperscript{143} These figures provide a rough estimate of the significant impact that the small employer exemption has on the scope of the Equity

\textsuperscript{139} See Claxton, supra note 80, at 193. Early numbers indicate that in response to the Equity Act, five percent of all firms to which the Act applies, dropped mental health coverage entirely. \textit{Id.} The fact that employers largely did not drop mental health coverage following the passage of the MHPA is linked to the fact that it permitted disparity in certain areas disparity in certain areas. U.S. GEN. ACCOUNTING OFFICE, supra note 33, at 5. Indeed, the majority of employers adapted by adopting the minimum level of parity necessary to comply with the MHPA. \textit{Id.} at 13-14. Although there are incentives for insurers to drop mental health benefits, doing so may result in forfeiture of grandfathered status, which would mean compliance with PPACA provisions would not be imposed on grandfathered plans. Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 34560-62 (June 17, 2010).

\textsuperscript{140} See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a(c)(1); see also supra note 57 accompanying text (detailing scope of small employer exemption). Even in situations where the Equity Act’s small employer exemption does apply, a state’s parity statute may apply as well. See supra note 124 and accompanying text (detailing extent to which state parity statute will not be preempted by Equity Act). This would not be the case, however, as applied to fully self-insured health plans. See supra notes 80-85 and accompanying text (summarizing scope of ERISA preemption).

\textsuperscript{141} Denavas-Walt, supra note 18, at 21-24. In fact, even though employment based insurance is the most likely source, the prevalence of employment based insurance was actually less in 2009 than in any other year in which comparable statistics were recorded, dating back to 1987. \textit{Id.}

\textsuperscript{142} Butani et al., supra note 57, at Table 1. It is important to note that this figure represents data from 2004, so applying it to data from later years only provides a rough estimate of the breakdown of the employees of firms of varying sizes. \textit{Id.}

\textsuperscript{143} See Claxton, supra note 80, at 48. Notably, the figures Claxton provides are not stratified according to the Equity Act’s small employer definition. See \textit{id.} Rather, the coverage rate of employees in firms with between three and twenty-four employees is reported as forty-four percent, and the coverage rate for employees in firms with between twenty-five and forty-nine employees is reported as fifty-nine percent. \textit{Id.}
Act’s protections.\textsuperscript{144}

Moreover, where the small employer exemption does apply, the failure of the controlling parity law to mandate true parity may effectively lock an individual into inadequate employer provided coverage.\textsuperscript{145} For example, assume that Debra works for and is insured through her employer, ABC Corporation, which has forty employees. Debra has been diagnosed with Anorexia Nervosa, for which she has been obtaining a variety of effective treatments, including therapy sessions, nutritional counseling, and medical treatment. While the group health plan ABC Corporation provides has covered her first fifteen therapy sessions, it imposes a limitation on the total number of sessions it will cover. Now that Debra has reached the ceiling of therapy sessions her group plan covers, she will be forced to either forego any additional treatments that she may still require, or she will have to pay for those treatments out-of-pocket.

Unattractive options remain for individuals who have secured health insurance from a small employer who self-insures or lives in a state with a parity law less comprehensive than the Equity Act.\textsuperscript{146} Realistically, because the small employer exemption allows for control of the costs of mental health care, including this exemption in a parity statute actually increases the likelihood that small employers will

\textsuperscript{144} See Butani et al, supra note 57, at Table 1; Claxton, supra note 80, at 48; BUREAU OF LABOR STATISTICS, THE EMPLOYMENT SITUATION – November 2010, available at http://www.bls.gov/news.release/pdf/empsit.pdf.

\textsuperscript{145} See infra notes 170-171 and accompanying text (discussing forces that may prevent those insured through grandfathered plans from obtaining alternative insurance on open market). Note, however, that because the Equity Act does not preempt more comprehensive state laws, where a state law either does not have or has a more comprehensive small employer exemption, the state law would apply. See Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5430 (Feb. 10, 2010) (to be codified at 45 C.F.R. pt. 146).

\textsuperscript{146} See supra note 124 and accompanying text. Specifically, an individual employed by a small employer in a state with a parity act less comprehensive than the Equity Act would only obtain the benefits her state’s parity statute mandates. Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5430 (Feb. 2, 2010) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 146). In contrast, a state law that provided mental health consumers with more protections than the Equity Act would not be preempted. Id. For example, in Connecticut, non-self-insuring small employers, as defined by the Equity Act, must comply with Connecticut’s parity statute, which contains no small business exemption. See id.; CONN. GEN. STAT. § 38a-514 (2010); see also TENN. CODE ANN. § 56-7-2360(a)(4) (2010) (exempting employers of two to twenty-five employees from Tennessee’s parity statute, in contrast to Equity Act, which exempts employers with two to fifty employees).
offer a health insurance plan with some measure of mental health benefits. Regardless of this fact, in situations where the health benefits obtained through such a plan are insufficient to cover the mental health services an individual requires, that individual would be forced to choose between two unattractive options: not obtaining the required services because the cost is prohibitive or paying for the services out-of-pocket, often at exorbitantly high prices.

The negative impacts the small employer exemption will impose on the parity outlook are mitigated by certain realities of the health insurance marketplace. As the size of a firm increases, employers are more likely to offer their employees health benefits. Employees of small employers that do not offer health insurance are likely to obtain insurance elsewhere, usually by directly purchasing it. Where insurance is obtained in a direct purchase transaction, insured individuals are more likely to obtain

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147 See Garcia, supra note 40, at 143 (providing explanation for presence of small employer exemption). But see Barrett, supra note 7, at 1196-97 (arguing that small employer exemption goes too far in undercutting parity statute and remedy lies in cost increase exemption).

148 Barrett, supra note 7, at 1160-61. This dilemma would more likely result in situations where an individual suffers from a severe mental illness. Id. at 1161. Even in the absence of a parity statute, health insurance coverage is typically sufficient to cover the costs of treatment for a less severe mental illness. Id. In contrast, where the mental disorder is severe, it is much more likely that an individual would be faced with higher cost options. Id. The costs of service often necessary in the case of severe mental illness—inpatient hospitalization—can often be as much as $7000 for three days. Id. at 1189.

149 See generally Claxton, supra note 80, at 35-44 (offering data compilations displaying positive correlation between employer size and health insurance offer rate).

150 See KAISER FAMILY FOUNDATION AND THE HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS 2010 ANNUAL SURVEY 29, 33-34 (Health Care Marketplace Project 2010), available at http://ehbs.kff.org/pdf/2010/8085-Section_2.pdf. Firms with three to nine employees are least likely to offer coverage, and only fifty-nine percent of them do so. Id. The prevalence of benefit offering increases as firm size increases—ninety-two percent of employers with twenty-five to forty-nine employees offer benefits. Id. Ninety-five percent of firms with greater than fifty employees offer health benefits. Id. There are several reasons for this disparity in benefit offering rates. Mark W. Stanton, Employer Sponsored Health Insurance—Trends in Cost and Access, 17 AGENCY FOR HEALTHCARE RES. & QUALITY 1, 4 (2004), available at http://www.ahrq.gov/research/empspsia/empspsia.pdf. The per-employee underwriting and administrative costs of offering health benefits decreases as the number of employees rises, which translates to higher premium costs in firms with fewer employees. Id. Higher rates of small firm failure provide an additional incentive not to offer health benefits. Id. Finally, because of relatively higher rates of turnover in small firms, the employees of small employers are less likely to survive waiting periods that employment based benefit programs typically impose. Id.

151 See Denavas-Walt, supra note 18, at 24-25. In 2009, fewer individuals obtained insurance by direct purchase than from other any other source, including employment-based and government-sponsored health plans. Id.
the benefit of more comprehensive state parity laws, which are not limited to employer provided coverage, and to the extent they are not preempted by ERISA, state parity laws more broadly regulate insurance companies.\footnote{152}

III. Potential Impact of PPACA on Mental Health Parity

A. Grandfathered Plans

PPACA provides insured individuals with the “right to maintain existing coverage.”\footnote{153} Although the inclusion of this provision may have been a necessary political compromise to pass health reform through Congress, such a provision will at least temporarily function to exempt existing plans from most of PPACA’s substantive reforms.\footnote{154} While PPACA explicitly states that the purpose of grandfathering plans is to allow those who are satisfied with their current coverage to maintain such coverage, there are several negative consequences of this provision, including potentially less comprehensive mental health coverage.\footnote{155} Yet, despite some negative consequences implied by the manner in which grandfathered plans will be phased out, the IFR provide for various consumer protections that will subject previously grandfathered plans to the remainder of PPACA’s substantive reforms.\footnote{156}

The staggered nature in which PPACA will become effective has the added

\footnote{152 Compare CONN. GEN. STAT. § 38a-488a (2010) (regulating “each individual health insurance policy”), and MASS. GEN. LAWS ch. 175, § 47B (2010) (applicable to “individual [policies] of accident and sickness insurance”) and N.J. STAT. ANN. § 17:48-6v (West 2010) (governing “[e]very individual and group hospital service corporation contract”), with Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a(b) (only regulating a “group health plan or health insurance coverage offered in connection with such a plan”).}


\footnote{154 See supra note 101 and accompanying text (discussing various reforms with which grandfathered plans will have to comply).}

\footnote{155 See infra notes 164-170 and accompanying text (analyzing market forces preventing individuals enrolled in grandfathered plans from obtaining more comprehensive coverage).

\footnote{156 See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34560-62 (June 17, 2010); see also supra notes 103-105 and accompanying text (outlining various actions related to elimination of treatment and non-compliant pricing changes that will result in forfeiture of grandfathered status).}
implication that in certain respects, a grandfathered plan will initially function more as a safe harbor for insurance providers than as a benefit for health care consumers. Specifically, although PPACA prohibits all grandfathered health plans from imposing lifetime limits on essential health benefits, including mental health care, substance abuse treatment, and behavioral health care as of the day of its passage, initially there will be only a limited restriction on the capacity of grandfathered group plans to impose annual limits. Moreover, for those who obtain coverage through a grandfathered individual policy, PPACA does not prohibit insurers from imposing annual limits. The outright proscription on annual limits will not be effective until 2014, at which point the reform will function as a substantial protection for health care consumers. Until that time, however, the allowance of annual limitations has the potential to limit access to comprehensive mental health benefits.

However, in addition to the eventual proscription of annual and lifetime limits, some other substantive reforms that will be immediately imposed upon grandfathered plans have the potential to provide those in need of mental health care with significant


158 Patient Protection and Affordable Care Act of 2010 § 1001 (to be codified as amended at 42 U.S.C. § 300gg-11); see also 75 Fed. Reg. at 37236. Specifically, the Rules specify the yearly increase of the annual limit until 2014, when such limits will be banned. Id. at 37192. The annual limits the Rules specify are as follows: $750,000 for 2010, $1,250,000 for 2011, and $2,000,000 from 2012 until 2014. Id. Annual limits will be phased out gradually because it is anticipated that prohibiting the imposition of annual limits would result in the rise of insurance premiums. Id. at 37191.

159 75 Fed. Reg. at 37191.

160 Id. The regulation of annual and lifetime limits are applicable to all plans, not just grandfathered plans. Id. (specifying regulations to be applicable to “a health insurer offering group or individual health insurance coverage”). There are separate provisions relating to when modifications of annual or lifetime limits in existence prior to the passage of PPACA will result in the forfeiture of grandfathered status. Interim Final Rules for Status as Grandfathered Health Plans, 75 Fed. Reg. 34538, 34560 (to be codified at 54 C.F.R. § 54.9815-1251T).

161 See generally 75 Fed. Reg. at 37236 (setting forth allowable annual limits). In the abstract, the allowable annual limits appear to be adequate to cover an individual’s mental health needs. Id. It is worthwhile to note, however, the rate at which certain mental health costs—particularly the cost of inpatient hospitalization, the necessity for which is most likely to arise in response to serious mental illness—has risen in the past several decades. See Barrett, supra note 148, at 1189 (highlighting exorbitant costs of inpatient psychiatric hospitalization).
Specifically, there are several provisions in PPACA that will enhance the accessibility of health care, and by extension mental health care. Among these access-increasing provisions include the requirement to extend coverage to dependents, the prohibition against rescissions, and the proscription against excessive waiting periods.

B. Tradeoffs and the Phasing out of Grandfathered Plans

As noted above, in several respects, the grandfathered plan provision of PPACA will function as a boon to the accessibility and comprehensiveness of mental health coverage. Because of the way in which the IFR define the circumstances that lead to forfeiture of grandfathered status, as time passes, grandfathered plans will gradually be phased out. The extent to which grandfathered plans are phased out will function

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162 See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10103, 124 Stat. 119, 161 amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. §§ 300gg, 300gg-7, 300gg-8, 18011, 18013) (applying various provisions of sections 2704, 2711, 2712, 2714, 2715 and 2718 of Public Health Service Act to grandfathered plans). Notably, because many insurers are not required to offer mental health benefits at all, these reform provisions will immediately improve access to mental health care. See supra note 55 and accompanying text (describing Equity Act’s parity mandate). Because many grandfathered plans are expected to relinquish or be stripped of that status over time, these provisions will effectively enhance the accessibility of mental health care in such cases. See infra notes 164-168 and accompanying text (setting forth various actions and practices that will result in forfeiture of grandfathered status). But see infra notes 195-198 (discussing extent to which interaction of Equity Act and PPACA will mitigate this conclusion).

163 See Patient Protection and Affordable Care Act of 2010 § 1201 (to be codified as amended at 42 U.S.C. § 300gg-7) (prohibiting excessive waiting periods); id. § 1001 (to be codified as amended at 42 U.S.C. § 300gg-12) (prohibiting rescissions); id. § 1201 (to be codified as amended at 42 U.S.C. § 300gg-14) (extension of coverage to dependents); see also id. § 10103 (to be codified as amended at 42 U.S.C. §§ 300gg, 300gg-7, 300gg-8, 18011, 18013) (applying mentioned provisions of PPACA provisions to grandfathered plans). A waiting period, a term typically associated with individuals vying for coverage under a group health plan, is the period such an individual generally must wait prior to eligibility for benefits under the plan. Id. § 1201 (to be codified as amended at 42 U.S.C. §§ 300gg-7). PPACA prohibits group health plans from imposing any waiting period in excess of ninety days. Id. Quite simply, a rescission is when a health insurer decided to cease the extension of coverage and benefits to an already covered individual; PPACA prohibits rescissions except when the covered individual engaged in fraud or intentional misrepresentation. Patient Protection and Affordable Care Act of 2010 § 1001 (to be codified as amended at 42 U.S.C. § 300gg-12).

164 Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 34553. The regulations provide detailed predictions regarding the percentage of grandfathered plans that are likely to forfeit such status by 2013. Id. The range of estimates as to the percentage of small employer plans, defined as those insuring between three and ninety-nine employees, that are expected to forfeit their status is between twenty and forty-two percent by
as a benefit to mental health consumers because of the health care reform provisions that will be imposed upon non-grandfathered plans once PPACA has been fully enacted—most notably section 1302, which will mandate coverage of essential health benefits.

One way in which the phasing out of grandfathered plans will occur is through financial tradeoffs that all group health plan sponsors will inevitably face. In particular, the regulations pertaining to grandfathered plans dictate that various forms of cost increases in excess of expected rates of inflation, changes of annual limits, or elimination of benefits will result in forfeiture of grandfathered status. These rules of forfeiture will force health plan administrators to decide whether to keep up with the anticipated rate of health care inflation or lose grandfathered status. Further, while grandfathered status may be sufficiently valuable for some to comply with these requirements, in other cases, plan administrators will choose to comply with the substantive reforms not imposed on grandfathered plans, instead of complying with regulations necessary to maintain grandfathered status.

2011, between thirty-six and sixty-six percent by 2012, and between forty-nine and eighty percent by 2014. Id. Large employers, in contrast, are expected to relinquish their grandfathered status at a lower rate: between thirteen and twenty-nine percent by 2011, between twenty-four and fifty percent by 2012, and between thirty-four and sixty-four percent by 2013. Id. Plans offered by small employers are more likely to relinquish grandfathered status because small plans are more likely to make substantial changes to cost sharing, employer contributions, and health insurance issuers than large plans. FACT SHEET: KEEPING THE PLAN YOU HAVE: THE AFFORDABLE CARE ACT AND “GRANDFATHERED” HEALTH PLANS, http://www.healthreform.gov/newsroom/keeping_the_health_plan_you_have.html (last visited Apr. 13, 2011).

165 See generally 26 C.F.R. § 54.9815-1251T(g) (2010) (setting forth various plan modifications that will result in forfeiture of grandfathered status).

166 Id. The forms of cost increases that will result in grandfathered status forfeiture include “increase in percentage cost-sharing requirement . . . increase in a fixed-amount cost-sharing requirement other than a copayment . . . increase in a fixed amount copayment . . . [and] decrease in contribution rate by employers and employee organizations.” Id. § 54.9815-1251T(g)(1)(ii)-(v). Additionally, an insurance plan that eliminates substantially all benefits that are necessary to diagnose or treat a condition results in the insurance plan forfeiting its grandfathered status. Id. § 54.9815-1251T(g)(1)(i).

167 See id. § 54.9815-1251T(g)(1), (3). Specifically, several of the rules relating to forfeiture resulting from increased costs are linked to the rate of medical care inflation. Id. § 54.9815-1215T(g)(3). Insurers will be forced to decide whether it will be more costly for them to stay within the parameters that the rules establish or to maintain grandfathered status. See 26 C.F.R. § 54.9815-1215T(g)(3); see also FACT SHEET: KEEPING THE PLAN YOU HAVE: THE AFFORDABLE CARE ACT AND “GRANDFATHERED” HEALTH PLANS, supra note 164.

168 See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. at 34553 (predicting a large percentage of health plans to forfeit grandfathered status by
Not only will grandfathered plans present insurers with tradeoffs, but some individuals who are insured through grandfathered plans will be forced into difficult decisions regarding coverage as well. In many employment situations, employers pay a portion of an employee’s health care premium, which has the functional effect of reducing the cost of insurance for the employee.\(^{169}\) In a situation in which the insurance an employer offers under a grandfathered group plan provides mental health benefits that are inadequate, employees will be forced to either accept the coverage inadequacy or pay out of pocket for an alternative or additional policy.\(^{170}\)

Generally, one alternative source from which individuals could potentially obtain coverage is a HIE.\(^{171}\) In fact, to subsidize the cost of obtaining insurance, PPACA will provide premium tax credits for many of those who enroll in plans offered through HIEs.\(^{172}\) Excluded from the benefit of these tax credits, however, are individuals who are eligible for other coverage, including those eligible for coverage 2014); see also supra notes 89, 98-99 (setting forth some of substantive changes PPACA imposed upon non-grandfathered insurance offerings).

\(^{169}\) Claxton, supra note 80, at 70-96 (presenting statistics regarding breakdown of employer and employee contributions to health insurance).

\(^{170}\) See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 243, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 18091); id. § 10106 (to be codified as amended at 42 U.S.C. § 18091). This statute sets forth the various sources through which an individual can fulfill the mandate and thereby avoid the penalty corresponding with a failure to do so. Id. § 1501 (to be codified as amended at 42 U.S.C. § 18091); see also supra notes 90-91 and accompanying text (setting forth requirement to obtain minimum essential coverage). The sources through which an individual can obtain coverage sufficient to fulfill the mandate include government sponsored programs, employer-sponsored programs, plans in the individual market, or grandfathered coverage. Patient Protection and Affordable Care Act of 2010 § 1501(f) (to be codified as amended at 42 U.S.C. § 18091).

\(^{171}\) Id. § 1311 (to be codified as amended at 42 U.S.C. § 18031); supra note 94 and accompanying text (discussing structural changes to health insurance market that will be brought about through HIEs).

\(^{172}\) See Patient Protection and Affordable Care Act of 2010 § 1401(a) (to be codified as amended at 26 U.S.C. § 36). Not all of those enrolled in HIE qualified plans will obtain tax credits; those whose income is greater than 400 percent of the federal poverty limit will not be eligible. Id. § 1401(e)(1)(A) (to be codified as amended at 26 U.S.C. § 36). The federal poverty limits as of August, 2010 set the poverty line for a family of one at $10,830, for a family of four at $22,050, and for a family of eight at $37,010. Notices: Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010, 75 Fed. Reg. 45628, 45629 (Aug. 3, 2010). Those who are eligible for premium tax credits will also be eligible for reductions in cost-sharing. Patient Protection and Affordable Care Act of 2010 § 1402 (to be codified as amended at 42 U.S.C. § 18071). For example, the cost-sharing reductions will reduce the amount of the deductible according to the relationship between the individual’s income and the federal poverty limit. Id.
through a grandfathered plan.\textsuperscript{173} Therefore, for those individuals who are enrolled in grandfathered group plans in which employers are paying a portion of the premiums, it will most likely be more expensive to obtain coverage through an exchange, as a premium tax credit will not subsidize doing so.\textsuperscript{174} Once again, grandfathered group coverage that provides inadequate mental health benefits will leave covered individuals with the unattractive options of accepting the coverage inadequacies or paying higher premiums for more comprehensive coverage.

\textbf{C. The Individual Mandate}

The individual mandate does not specifically require individuals to obtain a health plan providing mental health benefits; and in certain cases, obtaining coverage that does not provide mental health benefits may fulfill the mandate.\textsuperscript{175} The PPACA language merely states that individuals must obtain minimum essential coverage, which can be fulfilled through insurance from several different sources, one of which is grandfathered coverage.\textsuperscript{176} Furthermore, grandfathered plans are not required to

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\item Patient Protection and Affordable Care Act of 2010 § 1401(e) (to be codified as amended at 26 U.S.C. § 36). In order to be eligible for the premium tax credits, an individual must be part of a tax filing unit, enrolled in a plan offered through a HIE, and have income below 400 percent of the poverty line. \textit{Id.} Additionally, individuals who were eligible for minimum essential coverage in any month are not eligible for premium tax credits for that month. \textit{Id.; see also id.} § 1501(f) (to be codified as amended at 42 U.S.C. § 18071) (setting forth PPACA's definition of minimum essential coverage). There is an exception to the rule disallowing those eligible for other minimum essential coverage from obtaining premium tax credits; some of those who are eligible for coverage through a grandfathered plan will also be eligible for the HIE premium tax credit, but only where the cost of premiums exceeded 9.8 percent of the individual's household income or the coverage fails to provide a specific ratio of value per dollar. Patient Protection and Affordable Care Act of 2010 § 1401(e)(2)(C) (to be codified as amended at 26 U.S.C. § 36). Note, however, that PPACA offers tax incentives encouraging small employers to contribute to their employee's coverage through a HIE. \textit{Id.} § 1421 (to be codified as amended at 26 U.S.C. § 45R, 26 U.S.C. § 38). When employers do make such contributions, however, the employees are not eligible for premium tax credits. \textit{Id.} § 1401 (to be codified as amended at 26 U.S.C. § 36).
\item See generally Patient Protection and Affordable Care Act of 2010 § 1501 (to be codified as amended at 42 U.S.C. § 18071) (providing PPACA provisions applicable to individual mandate); \textit{id.} § 10103 (42 U.S.C. §§ 300gg, 300gg-7, 300gg-8, 18011, 18013) (defining scope of reforms applicable to grandfathered plans).
\end{enumerate}
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provide essential health benefits, including mental health, substance abuse, or behavioral health services.\textsuperscript{177} Therefore, an individual may fulfill the mandate without obtaining mental health services.\textsuperscript{178}

Even though PPACA’s individual mandate does not specifically require an individual to obtain mental health care, its functional effect will be to greatly increase the number of individuals who have access to such services.\textsuperscript{179} By the time the mandate comes into effect in 2014, it is projected that somewhere between thirty-nine and sixty-nine percent of all employer-based grandfathered health plans will be phased out.\textsuperscript{180} As employer provided grandfathered plans are phased out, employees and their dependents will nonetheless still be required to fulfill the mandate and obtain coverage that abides by more of the substantive PPACA reforms.\textsuperscript{181} Thus, because non-grandfathered plans will be required to provide essential health benefits, those who previously did not have access to adequate mental health services under a grandfathered plan will gain such

to include government sponsored programs, employer sponsored plans, plans in the individual market, and grandfathered plans. \textit{Id.} § 1501(f)(1) (to be codified as amended at 42 U.S.C. § 18071).

\textsuperscript{177} See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34542 (June 17, 2010) (to be codified at 26 CFR pts 54 and 602) (outlining the reform provisions that are applicable to grandfathered health plans). The Regulations expressly state those reforms that are applicable to grandfathered plans but do not specifically include the coverage of mental health, substance abuse, or behavioral health services within that range. See \textit{id}. A canon of construction, \textit{expression unius est exclusion alterius}, dictates that “to express or include one thing implies the exclusion of another, or of the alternative.” \textsc{Black’s Law Dictionary} 661-62 (9th ed. 2009).

\textsuperscript{178} See supra notes 175-177 and accompanying text.

\textsuperscript{179} See supra note 92 and accompanying text (setting forth extent to which individual mandate will increase total number of insured individuals in nation).

\textsuperscript{180} Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act 75 Fed. Reg. at 34553. The projections are further stratified by employer size; forty-nine to eighty percent of small employers, which PPACA defines as those with less than one-hundred employees, are projected to forfeit the grandfathered status of their group health plans by 2014. \textit{Id}. In contrast, only thirty-four to sixty-four percent of large employers, which PPACA defines as those with greater than one-hundred employees, are projected to forfeit the grandfathered status of their health plans by the time the mandate is invoked. \textit{Id}.

\textsuperscript{181} Patient Protection and Affordable Care Act of 2010 § 1501 (to be codified as amended at 42 U.S.C. § 18071); see also supra notes 90-93 and accompanying text (explaining and discussing requirements of mandate and its likely impact on coverage). For the most part, forfeiture of grandfathered status will merely be the result of an employer modifying the terms of an employee benefit plan in a manner that violates the Regulations explaining PPACA’s grandfathering provisions. See supra note 103 and accompanying text.
Those who transfer from phased out grandfathered plans to an alternative source of coverage will not be the only individuals who benefit from the nationwide increase in access to mental health care. In the year prior to PPACA’s passage, uninsurance rates were at historically high levels, particularly for the impoverished members of American society. One of the main benefits of the individual mandate will be the manner in which it brings mental health services to millions of people who were previously uninsured. It is estimated PPACA will successfully provide health insurance to thirty-two million previously uninsured, non-elderly individuals. Those from the low-income demographic will in most cases be eligible for coverage either

182 See supra notes 90-93, 175-178 and accompanying text.
183 See Denavas-Walt, supra note 18, at 22. As of 2009, more than fifty million Americans were uninsured. Id. Not only is this a higher number of uninsured individuals as compared to any point in the last twenty years, but the percentage of unemployed individuals rose from 15.4 in 2008 to 16.7 in 2009. Id. at 22-24. Further analysis of the breakdown of uninsured individuals by household income reveals society’s impoverished as the most likely to be uninsured. Id. at 23. Among the lowest income bracket, households earning less than $25,000 annually, greater than twenty-six percent were uninsured in 2009. Id. In the next lowest bracket, which includes those households earning greater than $25,000 and less than $50,000, more than twenty-one percent were uninsured during the same period. Id. In comparison, the rates of the uninsured for the two highest household income brackets, $50,000 to $75,000, and $75,000 to $100,000, were 16 and 9.1 percent, respectively. Id. at 26.
184 See Letter from Douglas Elmendorf to Nancy Pelosi, supra note 92, at 9. A further benefit of the individual mandate is the effect it will have on the size of the overall risk pool. See Linda J. Blumberg, How Will the PPACA Impact Individual and Small Group Premiums in the Short and Long Term?, ROBERT WOOD JOHNSON FOUNDATION, at 2 (Jul. 2, 2010), available at http://www.urban.org/UploadedPDF/412128-PPACA-impact.pdf. Generally, larger insurance pools spread risk across healthy and unhealthy individuals. Id. This, in turn, has the effect of containing the cost of health care. Id.
185 See Letter from Douglas Elmendorf to Nancy Pelosi, supra note 92, at 9. Notably, this figure is composed of many impoverished individuals who will obtain coverage through a HIE or Medicare. See Denavas-Walt, supra note 18, at 23; Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010, 75 FED. REG. 45628, 45628-29 (Aug. 3, 2010). To a certain extent, however, individuals who are unable to afford insurance coverage will not be penalized for failure to do so. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1402(e), 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 18071). Specifically, under certain circumstances, the penalties that will be imposed on individuals who are not compliant with the mandate will not be imposed on “[a]ny applicable individual for any month if the applicable individual’s required contribution . . . for coverage for the month exceeds eight percent of such individual’s household income for the taxable year.” Id. § 1402(e)(1)(A) (to be codified as amended at 42 U.S.C. § 18071).
through Medicaid, or with the financial assistance of premium tax credits, through a HIE. Accordingly, the individual mandate will result in many of these individuals having access to necessary mental health services that were previously unavailable to them.

**D. The Interaction of PPACA and Parity Laws**

1. **The Interaction Between PPACA and the Equity Act**

Subject to a few exceptions and limitations, the interaction of the Equity Act and PPACA will require insurance providers to comply simultaneously with both laws. PPACA explicitly requires that health plans comply with the provisions of the Equity Act, but because the Equity Act predates PPACA, there is no explicit link from the former to the latter. Rather, PPACA is broadly applicable to insurance offered through both the group and individual markets, while the Equity Act only regulates group health plans.
The cumulative effect of these two pieces of legislation represents a monumental step forward for the parity movement. Although the Equity Act does not mandate the offering of mental health coverage, when combined with the essential benefits PPACA mandates, both laws, read together, will require mental health, substance abuse, and behavioral health services offered at parity with surgical and medical benefits. The extent to which insurance plans will be required to offer mental health coverage will be extended significantly through the substantive regulation of benefits that health plans will be required to offer under the fully enacted PPACA. Specifically, health plans offered through a HIE, the individual group market, or the small group market, will be required to offer certain mental health benefits. The fact codified as amended at 42 U.S.C. §§ 300gg-et seq., 18001-18003, 1320d note). Title I of PPACA contains many of the provisions that will substantively reform the health insurance marketplace. See id. For the most part, these reforms are broadly applicable to the health insurance market and therefore, influence the impact of Equity Act reforms. See, e.g., Patient Protection and Affordable Care Act of 2010 § 1001 (to be codified as amended at 42 U.S.C. § 300gg-et seq.) (reforming lifetime and annual limits, rescissions, preventive health services, extension of dependent coverage by broadly regulating “group health plan[s] and health insurance issuer[s]”). In contrast, the Equity Act is only applicable to group health plans. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a. 191 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1302, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 18022) (detailing parameters of essential health benefits package to be required of many insurance offerings beginning in 2014); Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 § 512, 29 U.S.C. § 1185a (setting forth mandated-if-offered parity mandate of Equity Act, which requires parity if insurance plans offer benefits of the nature PPACA requires); see also infra notes 193-194 (explaining result of integration of these statutory mandates).

192 Patient Protection and Affordable Care Act of 2010 §§ 1301, 1302(a) (to be codified as amended at 42 U.S.C. §§ 18021, 18022); see also supra notes 83-88 and accompanying text (discussing market reforms that will be imposed through application of section 1301 essential health benefits requirements).

193 Patient Protection and Affordable Care Act of 2010 §§ 1301, 1302(a), 1311 (to be codified as amended at 42 U.S.C. §§ 18021, 18022, 18031); see also supra notes 99-100 and accompanying text (outlining extent to which insurers will be required to provide specific mental health services under PPACA). As noted above, substance abuse disorders and behavioral health services will be included. See supra note 99-100 and accompanying text. It is necessary to note at this point that the availability of treatment will to a certain extent depend upon the definitions of mental illness, substance abuse disorder, and behavioral health services, which will be determined through regulations that will drafted pursuant to PPACA. See Patient Protection and Affordable Care Act of 2010 § 1302(b) (to be codified as amended at 42 U.S.C. § 18022). The manner in which the regulations are to be drafted must be consistent with “the scope of benefits provided under a typical employer plan.” Id. § 1302(b)(2)(A) (to be codified as amended at 42 U.S.C. § 18022). To ascertain what constitutes a typical employer plan, the Secretary will “conduct a survey of
that PPACA requires that insurers provide benefits for mental health, substance abuse, and behavioral health services is alone significant. When combined with the Equity Act’s mandated-if-offered parity mandate, the result will be a baseline of mental health benefits offered at parity with surgical and medical benefits.194

One important caveat to future enhanced parity requirements resulting from the interaction of PPACA and the Equity Act is the limitations placed upon each of the respective acts.195 For instance, small employers and those qualifying for the cost exemption will not be subject to the Equity Act but will be subject to PPACA.196 While those plans qualifying for Equity Act exemptions may be required to offer plans including PPACA’s essential health benefits, such plans will not be required to offer mental health benefits at parity. To the extent grandfathered plans do not qualify for Equity Act exemptions, the inverse will be true: while they will be subject to the Equity Act, they will not be subject to many PPACA reforms.197 Notably, grandfathered plans are not required to offer mental health, substance abuse, and behavioral health services, and as set forth supra in great detail, the Equity Act is ineffective as applied to health plans that are not required to offer such benefits.

Finally, the inconsistent definition of “small employer” in the Equity Act, as compared to PPACA, dictates that companies with between fifty-one and one hundred employees will not be exempted from the Equity Act.198 Indeed, the Equity Act defines employer-sponsored coverage to determine the benefits typically covered by employers.” Id. 

194 See 29 U.S.C. § 1185a; Patient Protection and Affordable Care Act of 2010 § 1302 (to be codified as amended at 42 U.S.C. § 18022). Indeed, the Equity Act makes clear that it alone does not require insurance providers to offer mental health benefits. 29 U.S.C. § 1185b(1). PPACA’s market reforms will make the Equity Act more effective by requiring the baseline of insurance offered to include certain mental health benefits. Patient Protection and Affordable Care Act of 2010 § 1302 (to be codified as amended at 42 U.S.C. § 18022). The Equity Act, in turn, will require that these benefits be offered at parity to medical and surgical benefits. See 29 U.S.C. § 1185a.

195 See generally supra notes 57-58 and accompanying text (noting small employer and cost exemptions to Equity Act); see also supra notes 101-105 and accompanying text (setting forth manner in which grandfathered plans will be a limiting factor on PPACA’s efficacy).


197 See 29 U.S.C. § 1185c(1)-(2).

a small employer as a firm with between two and fifty employees, while PPACA defines a small employer as having between one and one hundred employees. The result of these inconsistent definitions is that PPACA small employers with between fifty-one and one hundred employees will not qualify for the Equity Act’s small employer exemption and will have to abide by its parity requirements.

2. State Parity Laws and PPACA

Although PPACA will be binding on all health insurance plans, its provisions will merely set a baseline of coverage, and more comprehensive state laws will not be preempted. An example of this principle may be displayed in relationship to the benefits offered through a health plan. Beginning in 2014, to offer a health plan, whether through a HIE, the individual market, or the small group market, the plan must provide the essential health benefits package. Under section 1302, however, no health plan is prohibited from providing more comprehensive benefits than the essential health benefits, as the Secretary of Health and Human Services (“HHS”) defines. Therefore, nothing prevents states from mandating that insurance plans offer benefits more comprehensive than the essential benefits package.

E. PPACA and Health Care Outcomes

In addition to the market changes that are central to PPACA, focus is also

199 29 U.S.C. § 1185a(c)(1)(B) (defining small employer as applies to Equity Act as any employer with average of between two and fifty employees during business days in preceding calendar year).
200 Patient Protection and Affordable Care Act of 2010 § 1304(b)(2) (to be codified as amended at 42 U.S.C. § 18024). A small employer is defined as one with an average of at least one but not greater than one-hundred employees during the previous calendar year. Id.
201 Patient Protection and Affordable Care Act of 2010 § 1185a(1)(B). States, however, have the authority to harmonize the definitions of small employer in the two Acts for all plan years beginning prior to 2016. Patient Protection and Affordable Care Act of 2010 § 1304(b)(3) (to be codified as amended at 42 U.S.C. § 18024).
202 Patient Protection and Affordable Care Act of 2010 § 1321(d) (to be codified as amended at 42 U.S.C. § 18041). PPACA quite broadly states that “Nothing in this title shall be construed to preempt any State law that does not prevent the application of this title.” Id. (emphasis added).
203 Id. § 2707(a) (to be codified as amended at 42 U.S.C. § 1396a).
205 Id. § 1321(d) (to be codified as amended at 42 U.S.C. § 18041); see also text accompanying notes 202-204.
placed on improved quality and preventive care. Two preliminary comments are in order regarding these areas of focus in health care reform. First, the provisions related to quality care and prevention have the potential to positively impact mental health outcomes. Second, the same provisions could also potentially reduce costs of care.

PPACA has the potential to improve outcomes for mental health consumers if its quality improvement strategy is utilized to expand the use of evidence-based practices in the mental health care field. The “National Strategy for Quality Improvement in Health Care,” created under PPACA to promote better and more quality health care for Americans, sets forth the basic priorities around which the Secretary of HHS is charged to guide the effort; one such priority calls for the focus on those areas that have the greatest potential for improving outcomes for mental health consumers. In many cases, although evidence-based approaches have been effective in the mental health setting, the gap between research and practice has resulted in their under-utilization. Therefore, the field of mental health would appear to be an area in which PPACA’s quality improvement directive has the potential to improve patient care outcomes.

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206. See supra notes 106-114 and accompanying text (discussing PPACA strategy for quality improvement and focus on improving preventive care).
208. Id. § 3011 (to be codified as amended at 42 U.S.C. § 280j)). Several of the priorities around which the strategy is to be directed place reliance on the use of evidence-based measures that “have the greatest potential for improving the health outcomes . . . identify areas . . . that have the potential for rapid improvement . . . [and] emphasize quality and efficiency.” Id. PPACA contains additional language indicating the importance of evidence-based measures in the quality improvement strategy in the context of identifying appropriate quality measures. Id. § 3013(a)(4) (to be codified as amended at 42 U.S.C. § 280j)). In awarding grants and contracts for the development of quality measures, the Secretary is instructed to give priority to, among others, those measures that allow the assessment of health outcomes. Id.
209. Drake et al., supra note 107, at 179-80. Research has shown that evidence-based practices can improve outcomes as pertains to symptoms, quality of life, and functional ability. Id. at 179. Further study has shown that a large portion of individuals with mental illnesses who undergo a core set of interventions have been shown to improve outcomes. Id. A noteworthy example of this situation occurred in the treatment of schizophrenia in a state mental health system. Id. at 180. Although research has shown certain dosages of anti-psychotic medications to be effective, a minority of patients received the recommended dosage. Id. Moreover, even though psychosocial services, such as family interventions, were shown to be effective to improve outcomes, this form of treatment was likewise not provided to a majority of patients. Id.
210. Drake et al., supra note 107, at 181. Not all practitioners and mental health experts consider evidence-based practice to be ideally suited to the mental health field. See Tanenbaum, supra note 109, at 165-66. One of the sources of disagreement in this context is that some methods of mental health treatment, such as cognitive and behavioral therapies, are more susceptible to the well-respected evidence-based measurements than others, such as psychodynamic therapy. Id.
Realization of such a result, however, depends upon the committed application of the quality improvement strategy to the mental health field.\textsuperscript{211}

As PPACA holds the potential to improve outcomes in the field of mental health care through its quality improvement strategy, the integration of mental health care and primary health care similarly has the potential to achieve improved patient outcomes.\textsuperscript{212} Specifically, integration of mental services and medical services would facilitate increased access to and efficiency in obtaining mental health services.\textsuperscript{213} In many cases, research has shown that overall medical expenses are lower for individuals who have access to mental health care as opposed to those who do not.\textsuperscript{214} For example, numerous studies indicate that individuals who receive psychiatric therapy have lower long-term medical costs and lower morbidity than those who do not receive such care.\textsuperscript{215} Moreover, research shows that failure to treat depression results in various adverse

For example, while results attainable through implementation of cognitive and behavioral therapies may be measured by use of experimental research, such a scientific approach is not readily applicable to psychodynamic treatment mechanisms. \textit{Id.}

\textsuperscript{211} See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 3011-3013, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (to be codified as amended at 42 U.S.C. § 280j)). Although it is a possibility, it is not a foregone conclusion that the quality improvement strategy of PPACA will be applied to the field of mental health; authority to develop the strategy is vested in the Secretary of Health and Human Services. See \textit{id.} § 3011 (to be codified as amended at 42 U.S.C. § 280j)). While representatives from the mental health field will be represented in the strategy’s development—the interagency working group on health care quality includes representatives from the Substance Abuse and Mental Health Services Administration—representatives from many other fields, both within and without the health care industry, will also be part of the working group. \textit{Id.} § 3012 (to be codified as amended at 42 U.S.C. § 280j)). Not only is it essential that the individuals developing and implementing the strategy for quality improvement show a commitment to the field of mental health, but the practitioners who implement the evidence-based interventions and treatments must strictly follow the protocol for each particular treatment. See Drake et al., \textit{supra} note 107, at 180.

\textsuperscript{212} See Butler et al., \textit{supra} note 114, at 168.

\textsuperscript{213} See Butler et al., \textit{supra} note 114, at 21-22. The levels of integration providers adopted in the various studies Butler assessed were evaluated based on the extent to which linkage of communication and information between mental health and medical health practitioners was facilitated. \textit{Id.} Some of the specific manners in which access, awareness, and efficiency of communication were achieved included screening, medication, psychotherapy, coordination of care, clinical monitoring, and medication adherence. \textit{Id.} Moreover, studies were evaluated based on the extent to which the decision-making of mental and medical health practitioners was colocated and by consensus. \textit{Id.}

\textsuperscript{214} See Nadim, \textit{supra} note 64, at 320 (indicating individuals who receive mental health care tend to incur fewer medical costs over time).

\textsuperscript{215} See Nadim, \textit{supra} note 64, at 320.
effects, including morbidity due to suicide attempts, absenteeism, lost productivity, and reduced workplace productivity.\textsuperscript{216} Therefore, the integration of mental health and primary care has the potential to improve both patient outcomes and reduce health care costs in the long-term, by virtue of the increased utilization of mental health therapies that would result.\textsuperscript{217}

IV. Conclusion

The mental health parity movement has made remarkable strides since the early 1990s. At that point, an individual’s only recourse to obtain equality in mental health treatment was in petitioning a court for relief. The inconsistent results of such efforts rendered requesting the aid of courts an entirely unsatisfactory option. Since that time, the progress of the parity movement has been incremental and has primarily taken place through legislative efforts.

Although the first major federal legislation to address mental health parity, the MHPA, did not adequately solve the problem, it served as a societal impetus for change, as evidenced by the ensuing spate of state parity legislation. Such state parity statutes are in many cases quite comprehensive. The extent of their impact, however, is limited by the high percentage of the population that obtain insurance through sources that states are not authorized to regulate, including federal health care options and self-insured ERISA regulated health plans. These limitations necessitated a more satisfactory federal legislative solution than the MHPA; the answer to this call came, in part, through the Equity Act.

Undoubtedly, the Equity Act provides substantial improvements to the MHPA, and correspondingly, an improved outlook for mental health parity. Although the Equity Act symbolizes the culmination of a nearly two-decade struggle for parity in mental health, the law also represents a great shortcoming and need for further legislation. Specifically, the gap in coverage the small employer exemption represents seriously undermines the Equity Act’s effectiveness. Moreover, to the extent that the small employer coverage gap is mitigated by more comprehensive state parity legislation, the inability of the states to regulate self-insured health plans represents a separate but no less devastating omission from the reach of parity legislation. The small employer exemption to the Equity Act and ERISA preemption of state parity laws, however, are not the only areas in which further efforts toward parity are required. Most notable of

\textsuperscript{216} See Nadim, supra note 64, at 320-22; Butler et al., supra note 114, at 155, 157.

\textsuperscript{217} See Nadim, supra note 64, at 320-22.
the remaining inadequacies is the fact that the Equity Act does not require insurance plans to offer mental health benefits and only requires parity where such benefits are already offered.

Additionally, the passage of PPACA has the potential to impact mental health parity. In the long term, PPACA could potentially serve as a mechanism by which the Equity Act is rendered a more notable success for mental health parity. Once fully effective, PPACA will require most insurance plans to offer mental health, substance abuse, and behavioral health benefits as part of the essential health benefits package. Requiring health plans to offer mental health benefits will make the Equity Act’s parity mandate far more effective. Detracting from the potential advantages of PPACA’s interaction with the Equity Act, however, is the extent to which PPACA’s substantive provisions will not be imposed on grandfathered plans. The impact of this PPACA provision will largely depend upon how many initially grandfathered-in plans are ultimately phased out.

In a more general sense, a further benefit of PPACA is the extent to which it will increase the general public’s access to mental health care. Most notably, the individual mandate will bring insurance coverage to millions of previously uninsured individuals. The positive impact that could result from the mandate, however, is under threat of legislative and judicial repeal. Future court and legislative decisions will dictate whether the potential benefits related to this provision will ultimately come to fruition. Additionally, the integration of mental health and primary care services holds the potential to enhance the accessibility of mental health services, as well as improve patient outcomes. Enhanced access to such services will also be dependent upon the contingency of future events, particularly decisions regarding the manner in which PPACA will be implemented.

In sum, the Equity Act and PPACA represent but two steps along a long path, at the end of which lies parity in mental health care. To refer to the impact of these legislative acts as mere steps along a path does not fail to recognize substantial improvements that have been accomplished. Rather, it is merely recognition of the fact that despite the Equity Act’s progress, there are still individuals who do not have equitable access to mental health care. Fortunately, PPACA, which will extend the impact of the Equity Act, puts the prospect of a further step toward mental health parity within reach.