The Mental Health Parity Act: Opening the Door to Equitable Access for the Mentally Ill

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I. INTRODUCTION

It has long been believed that the disparities associated with healthcare stem from three prongs: cost, quality, and access. Indeed, it is often the interplay between these three prongs that affects consumers’ relations with the healthcare system, and together they can combine to form great impediments in access to care.¹ Access to mental healthcare is never immune from the effects of this three pronged system, but in the past, consumers of mental health services have been faced with an additional barrier to access: discrimination by private insurer’s in the coverage of mental health services.²

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² See infra notes 12-23 and accompanying text (discussing ways in which private insurers have discriminated against full parity for mental healthcare services). The Mental Health parity movement began in the 1990’s for a variety for reasons: 1) research began to show that mental illnesses had biological as well as psychological bases, 2) during the 1970’s and 1980’s employers had implemented more restrictive coverage of mental illnesses, 3) increases in diagnoses due to improved diagnostic tools, and 4) growing opposition to the inequitable administration of mental healthcare benefits. Dana L. Kaplan, Can Legislation Alone Solve America’s Mental Health
In light of the ubiquity of persons suffering from treatable mental illnesses, the destruction of these barriers is imperative. Statistics indicate that there are approximately forty million American adults with some variation of a mental illness and that at least five to six million of those persons have a severe mental illness. It is because of this expansive effect on the populace, and because “mental health is essential to leading a healthy life,” that maintaining equitable access to treatment for mental healthcare is an issue of extreme importance.

Nonetheless, prior to the enactment of the Mental Health Parity Acts (MHPA) of 1996 and 2008, many employers and insurer’s discriminated against mental illnesses with respect to the extent of coverage. It is for this precise reason that the MHPA was promulgated, and proponents considered its passage to be a “great step forward” in the fight to end insurer’s discrimination of mental illnesses and the services required to treat such conditions.

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3 See infra notes 4-5 and accompanying text (noting number of persons that have some form of mental illness is around forty million).


5 Id.

6 Id. at 25. Parity refers to equality in coverage between physical conditions and mental health conditions.


8 A few scholars have discussed mental health parity laws in light of the conflict between state and federal legislation, utilizing real life stories of victims of such discrimination to underscore their pleas for reformed legislation. One such example involves a family whose son required constant mental health treatment; however, the family’s health insurance did not provide equitable coverage for mental illness. Desiree Busching & Simon Kapochunas, Timothy’s Law: Introducing New York to Mental Health Parity, 25 HOFSTRA LAB. & EMP. L. J. 601, 601 (2008) [hereinafter Timothy’s Law]. As a result, the son could not receive the treatment that he needed, and in 2001 he committed suicide. Id. Another such example involves a family whose son had attempted suicide, “prompting his parents to admit [their son] into a psychiatric hospital.” Jeffrey M.
Part II of this Article will discuss the history of the ratification of the MHPA of 2008 including a discussion of its direct predecessor, the MHPA of 1996. Part III will then discuss the sections and provisions of the MHPA of 2008 with a focus on those that pertain directly to parity in mental health coverage. Part IV will provide a brief analysis of the extent to which the MHPA of 2008 will achieve the goals of its supporters, including an assessment of outstanding issues to be addressed.

II. HISTORY OF PROMULGATION

The express purpose of the MHPA of 2008 was to balance the disparity between mental illness versus physical illness benefits, and thus, to increase access “by prohibiting group health plans from imposing financial requirements…or treatment limitations…on mental health benefits that are more restrictive than those restrictions applied to medical and surgical benefits.” Accordingly, the first sentence of the “purpose” of the MHPA of 2008 underscores that myriad “obstacles within our healthcare system prevent many

Barrett, A State of Disorder: An Analysis of Mental-Health Parity In Wisconsin and a Suggestion for Future Legislation, 2008 Wis. L. Rev. 1159, 1160 (2008) [hereinafter A State of Disorder]. The family had to pay over $130,000 out of pocket to cover the expenses not reimbursed by their insurance company; while at the same time the insurance company fully covered the entirety of the father’s care for his kidney disorder. Id. Such stories are illustrative of the impetus for both MHPA’s.

9 See infra Part II (discussing history of the MHPA of 2008 and the legislative purpose in its promulgation).

10 See infra Part III (highlighting the provisions of the MHPA of 2008 that specifically pertain to parity in coverage).

11 See infra Part IV (discussing the impact of the MHPA of 2008).

from getting the necessary mental healthcare. Though other laws existed prior to the MHPA of 2008, at the time of promulgation they were considered inadequate; and thus, a discussion of the previous laws is necessary to set the foundation for the response of Congress in enacting the MHPA of 2008.

There had been numerous attempts by legislators to introduce mental health parity legislation prior to the MHPA of 2008, but the most influential of these bills was the MHPA of 1996 which served as the direct predecessor to the 2008 MHPA. The MHPA of 1996, in an effort to quell the fears of its opponents that imposing mandates on parity would skyrocket costs, opted for a weaker parity provision that only required insurer’s to maintain annual and

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13 Id.
14 See infra note 15-16 and accompanying text (discussing history of prior laws and express purpose of enhancing the MHPA of 1996).
15 The Mental Health Parity Act of 2008 was a culmination of many previous efforts to pass legislation for mental health parity in insurance benefits. Below is a timeline of those previous recommendations:

1993: The Health Security Act to provide for full parity was debated and introduced, but again, the bill did not push into law. Id. at 13-14.
1996: Senators Domenici and Wellstone introduced the MHPA of 1996 which required parity only in annual and lifetime dollar limits on health insurance benefits. Id. at 14. This was signed into law on September 26, 1996. Id.
1997: The MHPA of 1996 requirements were extended to the State Children’s Health Insurance Plan and Medicaid managed Care plans, and the Taxpayer Relief Act of 1997. Id. at 15.
1998: Senator Roukema made another attempt to amend the code by introducing the Mental Health and Substance Abuse Parity Amendments of 1998, but they were not passed into law. Id. at 15.
1999: Senators Domenici, Wellstone, and Roukema introduced, respectively, the Mental Health Equitable Treatment Act and re-introduced the Mental Health and Substance Abuse Parity Amendments. Id. After hearings before committees, no further action was taken on the latter. Id. at 16. Both bills were reintroduced in 2001 and 2002. Id. at 15-16.
2001 – 2007: Myriad other bills were introduced and rejected. Id. at 16-20.
17 See id. at 27-28 (discussing previous MHPA and the concerns for balancing costs with increased access).
lifetime dollar limits that were equal to those allowed for physical conditions. As a result of these limited parity provisions, the MHPA of 1996 did not produce “fundamental change” and “arbitrary” discrimination against persons seeking coverage for mental healthcare persisted. Instead of responding to the mandate for parity, insurer’s merely imposed new limitations on mental health coverage. As a result, the status quo of discrimination remained in effect, foreclosing access to care for persons that were insured by such plans and unable to independently pay for mental health services.

The express language of the MHPA of 2008 states that its goal was “to expand the MHPA of 1996 to ensure that mental illnesses are covered under similar terms as physical illnesses…” Moreover, at the time of the promulgation of the MHPA of 2008, twenty-eight states had “full mental health parity” laws but such laws varied greatly in language and effect. In part because of this variance, supporters of the MHPA of 2008 recognized that “without a

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20 Id.
21 Id. (Insurers and employers frequently utilized loopholes such as more restricted coverage for outpatient visits than with physical conditions, reduced coverage for hospital days, and higher cost sharing requirements).
22 Id.
23 See, e.g., supra note 8 (discussing stories of families affected by inability to pay, and insurers refusal to pay, for mental health services).
25 Id. at 30-31 (citing to deficits in existing state laws including that they cannot apply to self-insured plans because of ERISA preemption and that even the full state parity laws fail to cover “catastrophic care” in the situations of severe mental illness). In addition to the 28 states with full parity laws, the Report to the bill highlighted that 46 states in total had some form of mental health parity law but that “they var[ied] considerably…divided into three categories:” 1) full parity, 2) minimum standard, and 3) offering laws. Id. at 30.
26 Id. at 31.
definition of covered mental health benefits, mental health parity legislation would continue to include loopholes that make parity an illusory promise.\textsuperscript{27} At the same time, public fears about costs and the stigma surrounding mental illnesses affected the public’s perception of parity laws.\textsuperscript{28} Thus, the MHPA of 2008 (the 2008 version alone will hereinafter be referred to as “MHPA”) sought to address all of these issues,\textsuperscript{29} and in 2008 the Employee Retirement Income Security Act (ERISA) was amended to include the provisions of the MHPA.\textsuperscript{30} Set to become effective on January 1, 2009,\textsuperscript{31} the MHPA promised a bright future for the end of healthcare discrimination and improved access to mental health services.

### III. PROVISIONS

As a result of the recognition that an effective federal health parity law would need to be predicated on “equity in financial requirements, treatment

\textsuperscript{27} \textit{Id.} at 20-21. Support for this contention was based on the idea that there was “ample evidence” to show that, in the past, employers had used narrow definitions of mental illness to “evade coverage” rather than reasonably restrict costs. \textit{Id.} The issue of coverage was also implicated by insurers varying definitions of mental illness. Whereas historically insurers did not “delineate” coverage for specific physical conditions, doing so with respect to the extent of coverage for mental illnesses was wide practice; “such delineation was commonplace.” \textit{Id.}

\textsuperscript{28} \textit{Id.} at 26. The Report to the Bill highlighted that in the late 1990s, the stigma surrounding mental illnesses resulted in a public that was hesitant to pay for services to treat “less severe” mental health conditions. \textit{Id.} This was exacerbated by the public’s belief that the coverage of those services would translate into higher premiums or taxes. \textit{Id.} The Former First Lady Carter’s testimony at the hearings concerning the passage of the MHPA of 2008 sums up the ideological underpinning of these concerns: “if insurance covered mental illnesses, it would be right to have them. This may be why the stigma has remained so pervasive. Because these illnesses are treated differently from other health conditions.” \textit{Id.}

\textsuperscript{29} See infra note 32 and accompanying text (noting the specific criteria on which the MHPA of 2008 was to be based).

\textsuperscript{30} 29 U.S.C. § 1185a (West 2009).

\textsuperscript{31} \textit{Id.}
limitations, and out of network coverage,” the MHPA mandates equitable coverage for treatment services. This includes: in and out of network inpatient, outpatient care, and emergency care; the number of visits or days of coverage; and “other similar limit[s] on the duration or scope of treatment.” Additionally, the MHPA mandates equitable financial coverage including deductibles, co-payments, co-insurance, out-of-pocket expenses, and annual and lifetime limits on coverage. These obligations encompass both mental illness and substance abuse benefits.

With respect to the definition of mental illness, the MHPA requires covered entities to adopt the “same range of mental illnesses and addiction disorders covered by the Federal Employee Health Benefit.” It is important to note, however, that though the MHPA does mandate parity, it does so only if the entity already provides mental health coverage; the MHPA does not create an affirmative responsibility to offer mental health coverage if an entity does not

37 See generally 29 U.S.C. § 1185a(a) (West 2009) (discussing general obligations under act and describing that such obligations apply for mental health and substance abuse disorders); H.R. REP. NO. 110-374, at 34.
38 29 U.S.C. § 1185a (West 2009); H.R. REP. NO. 110-374, at 34 (stating that plans must conform to the Federal Employee Health Benefit plan with the highest average enrollment of federal employees). Federal Employee Health Benefits are contingent upon state specific plan provisions, and even within each state, federal employee’s have panoply of plan options from which to choose. See, e.g., U.S. Office of Personnel Mgmt., 2009 Plan Information for Ill., Oct. 8, 2009, http://www.opm.gov/insure/health/planinfo/2009/states/il.asp (showing the thirty plus plan options just within the state of Illinois). Thus, this is a curiously vague standard for what was considered one of the most important provisions of the MHPA, that of which mental illnesses an employer is required to cover. H.R. REP. NO. 110-374, at 20-21.
already do so.\textsuperscript{39} Lastly, the MHPA expressly provides that unlike other ERISA provisions,\textsuperscript{40} the MHPA does not preempt more restrictive state mental health parity laws.\textsuperscript{41}

IV. Analysis

Though the MHPA is a large step in the right direction towards ending the serious impediment to access based on discrimination, studies performed in states in which parity laws already exist suggest that the MHPA may not result in the anticipated wider access of mental health services even if it creates an easier means through which services can be accessed.\textsuperscript{42} Even though studies suggest that parity does not affect premiums,\textsuperscript{43} they also show that while parity may increase access for those persons already suffering from mental illness, the

\textsuperscript{39} 29 U.S.C. § 1185(b) (West 2009); H.R. Rep. No. 110-374, at 24. The bill also allows for an exemption for group health plans for which implementation would result in a 2% cost increase the first year and 1% each subsequent year, and also to employers with fifty or fewer employers and those that would also experience greater than a 2% increase in cost during initiation year and 1% each subsequent year. 29 U.S.C. § 1185(c)(1); H.R. Rep. No. 110-374, at 34. The Congressional Budget Office demonstrated, however, that the estimated cost increase was at 0.4% for private insurers, and 0.2% for public insurers. H.R. Rep. No. 110-374, at 45.

\textsuperscript{40} ERISA preemption is a peripheral but important legal issue with respect to the MHPA. ERISA governs “any benefit plan that is established or maintained by any employer engaged in commerce or in any industry affecting commerce.” 29 U.S.C. § 1003(a) (West 2006). ERISA contains a preemption clause which expressly provides that ERISA provisions supersede state laws that pertain to employee benefit plans. 29 U.S.C. § 1144(a) (West 2006); Timothy’s Law, supra note 8, at 624-25. ERISA, however, also contains what is commonly referred to as the “savings clause,” which allows states to regulate insurance provided that certain legislative criteria are met. 29 U.S.C. § 1144(b) (West 2006); Timothy’s Law, supra note 8, at 625. Thus, both the savings clause and the plain language of the MHPA create substantial enhancements to access of mental health services by allowing states to create more restrictive parity laws and still avoid preemption for those plans governed by ERISA.

\textsuperscript{41} H.R. Rep. No. 110-374, at 34-35 (“nothing in this section preempts any State law that provides consumer protections…except to the extent that such provision prevents the application of a requirement of this part”).

\textsuperscript{42} See infra notes 42-44 (discussing studies looking at effect of state parity laws).

\textsuperscript{43} Timothy’s Law, supra note 8, at 610. The study, however, did show that “[n]one of the insurers….identified [mental health or substance abuse] parity laws as a main consideration in a decision to self-insure.” Id. at 610-11.
passage of such laws does not per se increase utilization of mental health services.\textsuperscript{44} This may be exacerbated by the MHPA’s failure to provide an adequate standard by which insurers must define the breadth of mental illness coverage;\textsuperscript{45} with the likely result of litigation as the MHPA’s effects settle and the potential arises for continued abuse of statutory loopholes.

Additionally, it is self-evident that the passage of the MHPA only affects those participants of a covered entity. Thus, a myriad of other barriers continue to exist for the mentally ill with respect to access of care. Such barriers include low access for minorities\textsuperscript{46} and the remaining stigmas that pervade our society that may contribute to the hesitancy in obtaining the requisite mental healthcare.\textsuperscript{47} Indeed, as the MHPA only applies to private insurers and only to insurance coverage, it neglects the issue of the uninsured and a lack of access to not only compensation for coverage, but providers and facilities in and of themselves.\textsuperscript{48}

These issues of basic, physical access to services are particularly important to

\textsuperscript{44} Id. at 612.
\textsuperscript{45} See supra note 38 and accompanying text (discussing pervasive vagueness of the specific mental illnesses that insurer’s are required to cover).
\textsuperscript{46} See generally Matt Boucher, Turning a Blind Eye in Legislating Mental Health Parity: The Unmet, Overlooked Needs of the Working Poor in Racial and Ethnic Minority Communities, 19 J. CONTEMP. HEALTH L. & POL’Y 465 (2003) (criticizing myopic view of parity legislation as only within the context of private insurers). Boucher underscores one of the primary problems with legislation focused only on private insurers: 85-95% of those with treatable, severe mental illnesses are unemployed, and thus wholly unaffected by the MHPA. Id. at 469. As Boucher notes, racial and ethnic minorities also have disproportionate impediments to access due to lower physical access to mental healthcare facilities. Id. at 471, 473, 488. Boucher argues that parity legislation should coincide with an expansion of community based mental health programs as these are often the most utilized and only means of receiving mental healthcare for the working poor and minority populations. Id. at 489-91.
\textsuperscript{47} State of Disorder, supra note 8, at 1162-63 (citing one effect of stigma is to preclude “the market from addressing the discrimination from mental health coverage…”). Id. at 1162. This is exacerbated by the stigma that “erodes confidence that mental disorders are valid, treatable health conditions.” Id. (internal citation omitted).
\textsuperscript{48} See supra notes 46-47 and accompanying text (discussing remaining gaps in access to mental health care for the uninsured).
address in light of the MHPA’s proponents’ indications of the high costs, both economic and social, of untreated mental illness.49

V. CONCLUSION

The MHPA was seen as “one more step in the long civil rights struggle to ensure that all Americans have the opportunity to reach their potential.”50 While the practical results of the MHPA have yet to be assessed, there is hope that by the time of the 2012 Government Accounting Office’s mandated analysis, the MHPA’s goals will have materialized.51 In fact, it is because the MHPA was “one of the most dramatic improvements in the [availability of] healthcare…for people who have mental illness”52 that there are such high expectations for the bill’s effect. If, however, insurers continue to abuse the loopholes of the perceptively vague language of the MHPA, supporters of the MHPA may

49 Legislation Alone, supra note 2, at 330-31 (“studies have found that individuals with untreated mental illness use non-mental health services at a high rate than individuals without mental illness. This…leads to higher overall health costs…individuals suffering from untreated mental illness have higher unemployment and disability rates than individuals not suffering from mental illness.”). See also A State of Disorder, supra note 8, at 1166 (“the annual cost of untreated mental illness in the United States is an estimated $148 billion.”).

50 Fred Frommer, After 12 Years, Wellstone Mental Health Parity Act is Law, Minn. Public Radio (Oct. 3, 2008) http://minnesota.publicradio.org/display/web/2008/10/03/parity_finalpassage (citing Representative Patrick Kennedy).

51 The MHPA requires the Labor Secretary to submit a report in 2012 and every two years following with the results of compliance audits and survey regarding compliance; and within three years the Government Accounting Office is required to submit a report analyzing the impact of the MHPA both on coverage of mental health and substance abuse services as well as the effect the MHPA has on costs to employers and insurers. See CuraLinc Healthcare, 2008 Mental Health Parity Act (2008) http://www.curalinc.com/parity.htm (describing background and requirements of the MHPA).

continue to see discrimination.\textsuperscript{53} Moreover, implicit discrimination will continue to exist so long as physical barriers to access pervade the uninsured.\textsuperscript{54} As the United States Supreme Court has stated, “[t]he mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.”\textsuperscript{55} Access to mental health services should embody this value.

\textsuperscript{53} See supra notes 38, 45 and accompanying text (highlighting vague sections in the definition of covered mental illnesses).

\textsuperscript{54} See supra notes 46-48 and accompanying text (discussing gaps in access for the uninsured and disadvantaged).

\textsuperscript{55} Jaffee v. Redmond, 518 U.S. 1, 11 (1996).