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Federal Efforts to Achieve Mental Health Parity: A Step in the Right Direction, But Discrimination Remains

Lucas Quass

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FEDERAL EFFORTS TO ACHIEVE MENTAL HEALTH PARITY: A STEP IN THE RIGHT DIRECTION, BUT DISCRIMINATION REMAINS

LUCAS QUASS*

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INTRODUCTION

Prior to the 1970s, many healthcare plans in the U.S. offered benefits without discriminating between mental health and general healthcare coverage.¹ In the 1970s and 1980s, the cost of healthcare increased dramatically and employers eliminated or limited mental health benefits in an attempt to reduce insurance costs.² To manage insurance costs, employers began using more cost sharing mechanisms and benefit caps on mental health benefits.³ However, these limitations were not applied equally to mental health and general health benefits and a coverage disparity was created.⁴

Today, insurers often do not provide coverage for mental health on the same terms as general health.⁵ Patients with mental illness face disability, dependence on social programs, incarceration, and homelessness,⁶ while the mental healthcare system remains separate from, and inferior to, the greater healthcare system.⁷ Private health insurance plans continue to discriminate against patients with mental illness and generally provide mental health coverage that is inferior in comparison to general healthcare coverage.⁸ Unfortunately, mental

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¹ See Dana L. Kaplan, *Can Legislation Alone Solve America’s Mental Health Dilemma? Current State Legislative Schemes Cannot Achieve Mental Health Parity*, 8 QUINNIPIAC HEALTH L.J. 325, 328 (2005) (discussing the emergence of the mental health parity movement).

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ U.S. GENERAL ACCOUNTING OFFICE, GAO/HEHS-00-9, MENTAL HEALTH PARITY ACT: DESPITE NEW FEDERAL STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED, 5 (2000) [hereinafter GAO].

⁶ RICHARD G. FRANK & SHERRY A. GLIED, MENTAL HEALTH POLICY IN THE UNITED STATES SINCE 1950: BETTER BUT NOT WELL 2 (2006). Although public social programs have been a key reason for improving the living conditions of people with mental illness, these programs do not provide enough resources to “lift” a person out of poverty. *Id.* In 1999, mentally ill people accounted for approximately 35% of public disability and 28% of welfare recipients. In 2001 approximately 30% of homeless single adults were mentally ill. *Id.*

⁷ Rep. Patrick J. Kennedy, *Why We Must End Insurance Discrimination Against Mental Health Care*, 41 HARV. J. ON LEGIS. 363, 365 (2004).

⁸ GAO, *supra* note 5, at 3.

illness remains on the fringes of the healthcare system, especially as it relates to access to medical treatment.⁹

Accordingly, the goal of the mental health parity movement is to require insurers to provide coverage for mental health on the same basis as general health.¹⁰ The term “Mental health parity”, generally means that insurance coverage for mental health services are subject to the same terms and restrictions as coverage for all other health services.¹¹ With this goal in mind, this article will provide a brief history of how the current inequality in mental health insurance coverage developed. Second, this article will examine the current debate around mental health parity and will consider arguments from opponents and proponents. Next, this article will examine and evaluate the effectiveness of state and federal parity legislation, including the Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equality Act of 2008 and the Patient Protection and Affordable Care Act of 2010. Finally, this article will advocate for additional parity protections and propose comprehensive federal parity legislation.

I. THE DEVELOPMENT OF INEQUALITY IN MENTAL HEALTH INSURANCE BACKGROUND/LEGISLATIVE HISTORY

The modern employment-based insurance system began as an employee recruiting tool during the Second World War and continued as a result of union advocacy and federal policy.¹² In 1958, 68% of the U.S. population was insured, with employers providing 75% of the insurance, nearly tripling the pre-war figure for employment-based insurance.¹³ In the late 1960’s, 92% of employment-based insurance offered some form of mental health coverage.¹⁴ As employment-based insurance became dominant in the 1960s, some plans implemented special restrictions on mental health services that were not applicable to other types of care.¹⁵ Restrictions on mental health services included: higher level of cost sharing (often as high as a fifty percent co-payment, lower utilization limits) and lower dollar caps on overall usage.¹⁶

Since the 1970s, health insurance policies have been moving further away from mental health parity.¹⁷ Mental health consumers now face

⁹ U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 426 (1999) [hereinafter SURGEON GENERAL 1999] (explaining that the term “[p]arity” refers to the effort to treat mental health financing on the same basis as financing for general health services.”).

¹⁰ *Id.*

¹¹ U.S. DEP’T OF HEALTH & HUMAN SERVS., PARITY IN COVERAGE OF MENTAL HEALTH SERVICES IN AN ERA OF MANAGED CARE, 7 n. 1 (1997) [hereinafter DHHS 1997].

¹² FRANK & GLIED, *supra* note 6, at 56-57.

¹³ *Id.* at 57.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ DHHS 1997, *supra* note 11, at 10. See also Kaplan, *supra* note 1, at 328.

higher deductibles, higher co-payments, lower policy limits for office visits, lower lifetime maximums and lower annual maximums.¹⁸ Thus, mental health coverage does not protect against catastrophic loss as the insurance industry merely offer coverage for “affordable financial losses and virtually no protection against large and potentially ruinous expenses for treatment of mental disorders.”¹⁹ Specifically, the lack of parity in mental health coverage has resulted in out-of-pocket expenses that are greatly disproportionate to that of general health.²⁰

As a result of this discrimination, mental health consumers are subject to a two-tiered healthcare system: one for the mind and one for the body. For example, a New York firefighter sustained a back injury during rescue efforts at Ground Zero and also suffers from Post Traumatic Stress Disorder (PTSD). His insurer provided unlimited care for his back treatment, but his mental health outpatient benefits were limited to twenty visits a year “regardless of the pain or disability he experiences, for his PTSD.”²¹

II. OPPONENTS OF PARITY: INADEQUATE JUSTIFICATION FOR DIFFERENTIAL TREATMENT OF MENTAL HEALTH

According to opponents of mental health parity, unequal mental health coverage arose due to market forces, specifically moral hazard and adverse selection.²² However, parity opponents fail to recognize the inapplicability of these market forces in a system of managed care and overlook the fact that the public mental health system has facilitated insurance discrimination.

A. MORAL HAZARD

Moral hazard represents the idea that as a healthcare plan becomes more generous, consumer demand for the plan’s services increases.²³ Specifically, “[m]oral hazard reflects a concern that if people with insurance no longer have to pay the full costs of their own care, they will use more services—services that they do not value at their full cost.”²⁴ Accordingly, increased demand results in higher utilization

¹⁸ DHHS 1997, *supra* note 11, at 12.

¹⁹ FRANK & GLIED, *supra* note 6, at 57.

²⁰ DHHS 1997, *supra* note 11, at 10 (explaining that approximately \$11 billion was spent out-of-pocket by mental health consumers in 2001 alone). *See also* FRANK & GLIED, *supra* note 6, at 51 (Table 4.1).

²¹ Sen. Paul Wellstone, *It’s Time to Act on Mental Health Parity Issue*, THE HILL, June 19, 2002, at 42.

²² FRANK & GLIED, *supra* note 6, at 57.

²³ DHHS 1997, *supra* note 11, at 12 (pointing out that, for example, if co-payments and general out-of-pocket expenses are lowered in a healthcare plan, then demand for health services under that plan will increase). *See id.* at 12.

²⁴ *See* Mental Health: A Report of the Attorney General, Financing and Managing Mental Health Care: History of Financing and the Roots of Inequality, <http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec3.html> (last visited Oct. 27, 2011) (discussing reasons for greater restrictions in coverage of mental illness).

and higher costs for the insurance provider.²⁵ Through moral hazard, over-utilization of benefits occurs when low cost insurance coverage reduces the consumer's economic incentives to economically utilize health services.²⁶ Moral hazard is applicable to the insurance industry as a whole, but is particularly applicable to mental health because the demand for mental healthcare coverage is more responsive to insurance benefits than general healthcare.²⁷

In fear of patient over-utilization, insurance providers have placed more restrictions and cost sharing mechanisms on mental health coverage.²⁸ A moral hazard justification for increased restrictions may have been true under the fee-for-service system, as empirical evidence shows the effect of moral hazard on mental healthcare demand.²⁹ For instance, the RAND Health Insurance Experiment found that an increased use of services by consumers in response to decreased cost sharing for mental healthcare was approximately double the observed rate for outpatient medical services under fee-for-service insurance.³⁰ However, the relevance and justification of moral hazard is doubtful under the current managed care system.³¹ Several studies have found that expanding mental health coverage under managed care has not resulted in substantial cost increases, thus diminishing concerns about moral hazard.³²

Under managed care, the utilization of benefits is rationed by healthcare providers.³³ Managed care integrates the delivery and financing of care with the underlying purpose of containing medical care costs.³⁴ In a managed care system, the effect of moral hazard is

²⁵ DHHS 1997, *supra* note 11, at 12.

²⁶ See Kaplan, *supra* note 1, at 338 (discussing opposition to mental health parity).

²⁷ See Richard G. Frank & Thomas G. McGuire, *Parity for Mental Health and Substance Abuse Care Under Managed Care*, 4 (Nat'l Bureau of Econ., Research, Working Paper No. 6838, 1998) [hereinafter Frank & McGuire] (discussing moral hazard in mental health care coverage).

²⁸ See Jeffrey M. Barrett, Comment, *A State Of Disorder: An Analysis Of Mental-Health Parity In Wisconsin And A Suggestion For Future Legislation*, 2008 WIS. L. REV. 1159, 1169 (2008) (discussing research which shows parity legislation has no measurable effect on the utilization of mental-health services). See also FRANK & GLIED, *supra* note 6, at 57 (discussing the economic phenomenon of moral hazard and its effects on mental health coverage).

²⁹ See Frank & McGuire, *supra* note 27, at 7 (discussing moral hazard's effect on increased restrictions on mental health care coverage).

³⁰ See generally Willard G. Manning, et al., The RAND Corp., *Effects of Mental Health Insurance: Evidence from the Health Insurance Experiment* (1989).

³¹ DHHS 1997, *supra* note 11, at 12. See also Colleen L. Barry & Susan H. Busch, *Do State Parity Laws Reduce the Financial Burden on Families of Children with Mental Health Care Needs?*, 42 HEALTH SERV. RES. 1061, 1064 (June 2007) (stating that research has shown that through managed care, the responsiveness of consumer demand can be curbed thus allowing increases in mental health coverage without imposing great cost on the insurer).

³² Goldman, W. J., et al., *Costs and Use of Mental Health Services Before and After Managed Care*, HEALTH AFFAIRS 17 (2): 40-52 (1998) (finding that after managed care "costs dropped by more than 40% in the six follow-up years, costs continued to decline slowly").

³³ Frank & McGuire, *supra* note 27, at 8.

³⁴ See also Barrett, *supra* note 28, at 1186 (discussing further how the lack of incentives to limit cost during the fee-for-service system led to "skyrocketing of mental-health costs in the mid-1980s" and the development of the managed care system).

removed because payment decisions are made *before* treatment.³⁵ Patients no longer have complete freedom to choose among physicians and physicians no longer have complete freedom to select among treatment options.³⁶ Thus, insurers have greater control over costs as well as greater control over access to treatment. Accordingly, the justification for differential treatment of mental health based on a moral hazard argument is flawed. Although managed care may reduce the affects of moral hazard, managed care does not create full parity, and access to mental health services still ranges widely among managed care plans.³⁷

B. ADVERSE SELECTION

Opponents of parity argue that adverse selection justifies differential treatment of mental health. The term “[a]dverse selection reflects a concern that, in a market with voluntary insurance or multiple insurers, plans that provide the most generous coverage will attract individuals with the greatest need for care, leading to elevated service use and costs for those insurers independent of their efficiency in services provision.”³⁸ Adverse selection applies to healthcare in general and describes the process where high cost consumer populations select health plans with more generous terms.³⁹ Therefore, as consumers select plans that fit actual or anticipated needs,⁴⁰ the most generous insurer will incur greater costs after being selected by high utilization consumers with the greatest need for care, such as mental health services consumers.⁴¹

According to this argument, insurers are incentivized by adverse selection to avoid the higher costs of “bad risk” health consumers and limit access to benefits.⁴² Thus, “[i]t has long been argued that good mental health benefits [will] attract costly users, and that insurers [have] an incentive to provide poor benefits to avoid these customers.”⁴³ As a result, the insurance industry has avoided the perceived additional cost of adverse selection by decreasing parity for mental health coverage.⁴⁴ Specifically, insurers have designed plans to allow fewer inpatient

³⁵ *Id.*

³⁶ *Id.*

³⁷ HAROLD E. VARMUS, NATIONAL INSTITUTES OF HEALTH, PARITY IN FINANCING MENTAL HEALTH SERVICES: MANAGED CARE EFFECTS ON COST, ACCESS, AND QUALITY 21 (1998) (noting that accessibility rates range “from 0.9 percent to 9.7 percent of members using outpatient specialty mental health services”).

³⁸ SURGEON GENERAL 1999, *supra* note 9, at 420, available at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c6.pdf>.

³⁹ DHHS 1997, *supra* note 11, at 12.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² FRANK & GLIED, *supra* note 6, at 57-58.

⁴³ FRANK & McGUIRE, *supra* note 27, at 6.

⁴⁴ DHHS 1997, *supra* note 11, at 12.

visits, higher out-of-pocket expenses, and lower annual and lifetime limits for mental illness than general health.⁴⁵

However, opponents of parity fail to recognize that adverse selection will be nullified when full parity is achieved. In a full parity insurance market, all plans will offer equal coverage for mental health; therefore, insurers will equally share the risk of over-utilization.⁴⁶ Further, opponents overlook the impact of managed care as a gatekeeper against over-utilization, which also serves to limit the effect of adverse selection.⁴⁷

C. THE IMPACT OF THE PUBLIC MENTAL HEALTHCARE SYSTEM

The existence of a public mental healthcare system has facilitated limitations on mental health parity⁴⁸ by providing some mental health services to consumers and inadvertently competing with private insurance.⁴⁹ Since 1987, private insurance has accounted for around 21% of all mental health spending.⁵⁰ However, government expenditures have increased from 16.8% of all spending on mental health in 1971 to 34.7% in 2001.⁵¹ Thus, as insurers have increasingly limited mental health benefit since the 1970s, the federal government has increased expenditures for mental health.

Accordingly, the insurance industry has not met society's need for mental health insurance in an open competitive market.⁵² The perceived costs of moral hazard and adverse selection, along with the lack of a truly complete market, have led to inadequate coverage for mental health consumers.⁵³

⁴⁵ See, e.g. TIMOTHY A. KELLY, *HEALING THE BROKEN MIND: TRANSFORMING AMERICA'S FAILED MENTAL HEALTH SYSTEM* 95 (2009) (explaining that while insurers can do the same for other types of benefits, they are more likely to do so with mental health benefits).

⁴⁶ See, e.g., Maggie D. Gold, *Must Insurers Treat All Illnesses Equally?*, 4 CONN. INS. L.J. 767, 777 (2005) and Barrett, *supra* note 28, at 1170.

⁴⁷ See Kaplan *supra* note 1 (outlining opponents' arguments without mentioning role of managed care); see also *supra* text accompanying note 26.

⁴⁸ FRANK & GLIED, *supra* note 6, at 58.

⁴⁹ *Id.* at 51, 58 (noting in Table 4.1 that private insurance accounted for 12.3% of all spending on mental health services in 1971, 22.2% in 1987, 23.9% in 1997 and 21.9% in 2001).

⁵⁰ *Id.* at 51 (referring to Table 4.1).

⁵¹ *Id.* (noting that numbers provided are the combined total for Medicare and Medicaid).

⁵² *Id.* See also COMMUNITY VOICES, *THE DISPARITY CAVITY: FILLING AMERICA'S ORAL HEALTH GAP*, 1, 5 (2000) available at http://www.communityvoices.org/Uploads/fiok23y4gwhfkg45ksbde3jb_20020826095615.pdf. As the debate over mental health insurance parity continues, a parallel debate is occurring in the dental insurance industry. Similar to proponents of mental health parity who argue that mental health is more than just a condition of the mind, proponents of oral health parity argue that oral health is a condition of the body, not just the mouth. Proponents of oral health argue that the costs of under-insuring dental patients are as real as conditions affecting the body. Specifically, in 1989, a study found that as a result of dental problems children in the U.S. missed 52 million hours of school and adults missed 164 million hours of work. *Id.* at 1. It is estimated that half of the U.S. population does not have dental insurance, and one of the main reasons for the lack of coverage is the "cost of adding dental benefits to existing public and private insurance programs." *Id.* at 7.

⁵³ FRANK & GLIED, *supra* note 6, at 51-58.

III. THE CASE FOR EQUALITY IN MENTAL HEALTHCARE

As previously stated, the term “mental health parity” generally means that insurance coverage for mental health services are subject to the same terms and restrictions as coverage for all other health services.⁵⁴ The argument for this definition of parity was not as strong as initially presumed during the fee-for-service era.⁵⁵ However the argument for parity under the current managed care system is compelling because it allows for the welfare of mental health services consumers to be maximized.⁵⁶ This section will examine arguments made by proponents of parity legislation, the relationship of mental illness and general illness, the impact of mental illness on the economy, the minimal cost of parity legislation, and the role of social stigma.

A. IS MENTAL ILLNESS DISTINGUISHABLE FROM OTHER DISEASES?

“The human brain is the organ of the mind and just like the other organs of our body, it is subject to mental illness.”⁵⁷ Traditionally “the treatment of the mind . . . has been considered non-scientific and non-medical, mental illnesses have historically been regarded as shameful personal failings, rather than treatable diseases.”⁵⁸ However, research demonstrates that mental illness is not separate and unrelated from general health.⁵⁹

Although the exact cause of most mental illness is unknown, research has demonstrated that many mental illnesses result from a combination of various factors. Psychological factors that may influence mental illness include neglect, the loss of family early in life, and severe psychological trauma, such as emotional, physical, or sexual abuse.⁶⁰ Environmental factors that may influence mental illness include death, divorce, dysfunctional family, poverty and substance abuse.⁶¹ Further, a growing body of scientific research demonstrates that mental illness

⁵⁴ DHHS 1997, *supra* note 11, at 7 n. 1.

⁵⁵ See Frank & McGuire, *supra* note 27, at 5-7 (explaining that under the fee-for-service system, because the welfare costs created by moral hazard is greater for mental health than general health, due to a greater demand response, legislation seeking strict parity would not maximize mental health consumers’ welfare because the efficient level of coinsurance is higher for mental health than general health).

⁵⁶ *Id.* at 12.

⁵⁷ *Mental Health Parity: Hearing of the Senate Committee on Health, Education, Labor, and Pensions*, 106th Cong. 4-5 (2000) (statement of Sen. Pete V. Domenici).

⁵⁸ Kennedy, *supra* note 7, at 364.

⁵⁹ See, e.g., Kennedy, *supra* note 7, at 367.

⁶⁰ *What are the Causes of Mental Illness?*, THE KIM FOUNDATION, http://www.thekimfoundation.org/html/about_mental_ill/causes.html.

⁶¹ *Id.*

may be biochemical in nature⁶² and influenced by biological factors.⁶³ Specific biological factors include genetics, infections, brain injury, and prenatal damage.⁶⁴

Moreover, the Surgeon General has stated that a distinction of the mind from the body is not supported by science.⁶⁵ Accordingly, the stigma surrounding mental health should not dictate coverage. Stereotypes and false assumptions that mental illness is not caused by biological factors do not presume that with proper care, mental illness, like general illness, is treatable.⁶⁶ Accordingly, healthcare must be provided equally because mental illness is not separate from general illness.

B. MENTAL HEALTH INSURANCE DISCRIMINATION & THE ECONOMY

Mental illness has direct and indirect costs on the U.S. economy. Direct costs include: “medication, clinic visits, and hospitalization [and] are relatively easy to quantify, but they reveal only a small portion of the economic burden these illnesses place on society.”⁶⁷ For instance, in the U.S. in 1996, the direct cost for mental health treatment was \$66 billion, or roughly 7% of the nation’s health care costs.⁶⁸ Although this figure is significant, it is dwarfed by the indirect costs of mental illness.

Indirect costs of mental illness resulting from disability or premature death include lost earnings, homelessness, incarceration, and lost productivity at the workplace, school, and home.⁶⁹ The indirect costs of mental illness are more burdensome to society than direct costs, but are more difficult to quantify.⁷⁰ For instance, in 1985, the first estimate of lost earnings as a result of mental illness, as defined by the DSM-IV, was

⁶² Kennedy, *supra* note 7, at 367.

⁶³ See, e.g., *id.* at 367 n.39 (citing brain research from the National Institute of Mental Health that demonstrates the physiology of mental illnesses), ANNE ROGERS & DAVID PILGRIM, MENTAL HEALTH AND INEQUALITY, 128 (2003) (explaining that depression and dementia have underlying biological factors).

⁶⁴ See KIM FOUNDATION, *supra* note 60 (discussing biological, psychological, and environmental factors contributing to mental illness).

⁶⁵ SURGEON GENERAL 1999, *supra* note 9, at 5-6.

⁶⁶ See Lorraine Schmall, *One Step Closer to Mental Health Parity*, 9 NEV. L.J. 646, 665 (2009) (discussing that employers may “exclude illnesses based on stereotypes, false assumptions, or costs . . . [while] overestimat[ing] the cost of providing mental health insurance”).

⁶⁷ See Press Release, Nat’l Inst. of Mental Health, Mental Disorders Cost Society Billions in Unearned Income (May 7, 2008), available at <http://www.nimh.nih.gov/science-news/2008/mental-disorders-cost-society-billions-in-unearned-income.shtml> [hereinafter NIMH Press Release] (discussing the costs of mental disorders).

⁶⁸ SURGEON GENERAL 1999, *supra* note 9, at 412.

⁶⁹ *Id.* at 411; see also NIMH Press Release, *supra* note 67 (discussing the costs of mental disorders).

⁷⁰ NIMH Press Release, *supra* note 67 (discussing studies on the indirect costs arising from mental disorders).

\$44.1 billion.⁷¹ In 1992, the estimated economic loss was \$77 billion.⁷² Further, research revealed that in 2002, the U.S. economy lost \$193 billion in annual earnings as a result of serious mental illness alone.⁷³

The total amount of lost earnings in the U.S. as a result of serious mental illness has been increasing. For instance, in 1992, total of lost earnings as a result of serious mental illness was \$76 billion.⁷⁴ Although these figures are staggering, these estimates are conservative as they did not include all indirect costs of mental illness and the data did not include patients who suffer from chronic mental illness such as schizophrenia or autism.⁷⁵

Considering the economic loss due to mental illness, parity legislation is needed to reduce economic loss and to increase the quality of care for mental health consumers. Parity legislation will reduce the economic loss to society by ensuring that mental illness will not go untreated because of insurance discrimination. It is established that untreated mental illness incurs a great economic loss to business and society.⁷⁶ For example, clinical depression in 1995 cost businesses in the U.S. approximately \$28.8 billion in lost productivity and increased use of sick leave.⁷⁷ Tragically, “[l]ost earnings due to depression-induced suicide total[ed] \$ 7.5 billion,” yet, when treated, “the success rate for clinical depression is over 80 percent.”⁷⁸

Increasing access to treatment also has a direct benefit for employers. Research has shown that work productivity will improve by three hours if a depressed employee receives enhanced treatment weekly,⁷⁹ thereby reducing indirect costs to employers and society. For instance, researchers have found that “when savings for general medical services and indirect costs are considered, providing mental health coverage commensurate to physical health coverage for all U.S.

⁷¹ See Ronald C. Kessler et al., *Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication*, 165 AM. J. OF PSYCHIATRY 703, 703 (2008) (citing an estimate made by Rice et al. in a report commissioned by the U.S. Public Health Service, which used data from the National Institute of Mental Health (NIMH) Epidemiologic Catchment Area (ECA) study).

⁷² See *id.* (citing an updated estimate by Harwood et al. in a report commissioned by NIMH that used data from the National Comorbidity Survey (NCS)).

⁷³ See *id.* at 707 (attributing the increase from prior estimates to inflation and controlling for education, marital status, and household size).

⁷⁴ See Thomas R. Insel, *Assessing the Economic Costs of Serious Mental Illness*, 165 AM. J. OF PSYCHIATRY 6 (2008) (discussing components of the economic burden of serious mental illness (see Table 1)).

⁷⁵ NIMH Press Release, *supra* note 67.

⁷⁶ See e.g., SURGEON GENERAL 1999, *supra* note 9, at 360, 411, 413; *Assessing Mental Health Parity: Implications for Patients and Employers: Hearing Before the Subcomm. on Employer-Employee Relations of the H. Comm. on Educ. and the Workforce*, 107th Cong. 148, appendix O (2002) [hereinafter *Relations Hearing*] (statement of the American Medical Association).

⁷⁷ *Relations Hearing*, *supra* note 76, at 148.

⁷⁸ Kaplan, *supra* note 1, at 332.

⁷⁹ Phillip S. Wang, *Telephone Screening, Outreach, and Care Management for Depressed Workers and Impact on Clinical and Work Productivity Outcomes: A Randomized Controlled Trial*, 298 J. OF THE AM. MED. ASS'N, 1401-11 (Sept. 26, 2007).

children and adults would actually amount to a net annual savings of \$2.2 billion.”⁸⁰ Thus, by providing mental health parity, a significant portion of indirect costs will be saved.

When insurers consider adverse selection and moral hazard, they attempt to save resources by restricting access to mental health coverage,⁸¹ even though research has shown that cutting access to service and treatment will increase overall costs. Mental health consumers may overuse mental health insurance benefits and increase insurance costs;⁸² however, by providing greater access to services and treatment, overall costs to the employer and society will decline.

Several studies have illustrated the inverse relationship between greater access to treatment and reduced cost for employers and society. For example, a Connecticut employer reduced mental health coverage for employees in an attempt to reduce costs and initially saved 30%, but merely shifted the savings from mental health to general health as “it saw a 37% increase in medical care expenses and sick leave use by employees who needed mental health services.”⁸³ By reducing coverage for mental health, employees shifted mental health costs to general healthcare expenditures and increased the direct and indirect cost of mental illness.⁸⁴ Accordingly, mental health parity legislation will improve the lives of mental health consumers and reduce the impact of mental illness on the economy.

C. THE MODEST COST OF EQUALITY: WE CANNOT AFFORD NOT TO

The cost of inadequate mental healthcare is large, but the financial cost to reduce this burden is minor.⁸⁵ In 2007, the Congressional Budget Office (CBO) estimated that federal mandated parity legislation, with a broad DSM definition of mental illness, would increase premiums for group health insurance by approximately 0.4% if offered.⁸⁶ Further CBO estimates that the direct costs of mandated services would be equivalent to 0.4% of employer-sponsored health insurance premiums.⁸⁷

Additional studies have confirmed the CBO estimate, “pegging the

⁸⁰ Gillian Friedman, *The Case for Mental Health Parity*, available at http://www.abilitymagazine.com/Mental_Health_Parity.html

⁸¹ Kaplan, *supra* note 1, at 330.

⁸² See, e.g., KELLY, *supra* note 45, at 95.

⁸³ See, e.g., Kaplan, *supra* note 1, at 331; Robert A. Rosenheck et al., *Effect of Declining Mental Health Service Use on Employees of a Large Corporation*, 18 HEALTH AFFAIRS 193, 194 (1999).

⁸⁴ Roger Kathol, Steven M. Saravay, Antonio Lobo, & Johan Ormel, *Epidemiologic Trends and Costs of Fragmentation*, 90 MED. CLIN. N. AM. 549, 561 (2006) (noting decrease in productivity and a 22% increase in absenteeism among users of behavioral health services after a reduction in coverage).

⁸⁵ Kennedy, *supra* note 7, at 372.

⁸⁶ CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE: H.R. 1424 PAUL WELLSTONE MENTAL HEALTH AND ADDICTION EQUITY ACT OF 2007 4 (Oct. 4, 2007), available at <http://www.cbo.gov/ftpdocs/86xx/doc8679/hr1424wm.pdf> [hereinafter COST ESTIMATE].

⁸⁷ *Id.* at 6.

cost of parity legislation at 1%, or \$ 1.32 per member per month.”⁸⁸ Further, the CBO estimated the total direct costs of parity at \$1.3 billion in 2008, and \$3.0 billion in 2012.⁸⁹ However, these cost estimates pale in comparison to the \$193 billion in annual earnings lost as a result of serious mental illness alone.⁹⁰ Thus, an argument that mental health parity is too expensive fails to realize that, as a society, we cannot afford not to have parity.⁹¹

D. THE STIGMATIZATION OF MENTAL HEALTH & UNEQUAL ACCESS TO HEALTHCARE

Most Americans are unaware of the discrimination faced by people suffering from mental illness. In fact, one study conducted in 2010 found that 7% of 2,940 participants had not even heard of the term “mental health parity.”⁹² Compounded with the lack of awareness is the fact that mental illness remains greatly stigmatized and stereotyped. In 1999, the U.S. Surgeon General concluded that “[f]or our nation to reduce the burden of mental illness, to improve access to care . . . stigma must no longer be tolerated.”⁹³

However, mental illness remains among the most stigmatized human conditions.⁹⁴ Recent research suggests that stereotypes of people suffering from mental illness are actually increasing “and that the stigma of mental illness remains a powerfully detrimental feature of the lives of people with such conditions.”⁹⁵ For instance, in 1950, a study questioned a nationally representative sample of adults about perceptions of mental illness⁹⁶ and a follow up study was conducted in 1996 to determine how perceptions had changed. The 1996 study

⁸⁸ Kennedy, *supra* note 7, at 373.

⁸⁹ COST ESTIMATE, *supra* note 86, at 7.

⁹⁰ *Supra* note 69 and accompanying text.

⁹¹ Moreover an examination of states with parity legislation shows that the cost of parity is modest. Kennedy, *supra* note 7, at 373 (demonstrating that states have experienced modest costs by adopting parity legislation, including Vermont, “where mental health and substance abuse spending [decreased] by 8% to 18% while increasing access to mental healthcare by 18% to 24%, Maryland, where “after a small rise of less than one percentage point in the year of transition to parity, mental health costs held steady in year two and declined in year three,” and Ohio, where “behavioral health costs for HMO enrollees fell following implementation of full mental health and substance abuse parity”).

⁹² *Your Mental Health: A Survey of Americans’ Understanding of the Mental Health Parity Law*, American Psychological Association Harris Interactive (2011), available at: <http://www.apa.org/news/press/releases/parity-law.pdf>.

⁹³ SURGEON GENERAL 1999, *supra* note 9.

⁹⁴ GARRY MORRIS, MENTAL HEALTH ISSUES AND THE MEDIA 47 (2006).

⁹⁵ Bruce G. Link, Jo C. Phelan, Michaeline Bresnahan, Ann Stueve, & Bernice A. Pescosolido, *Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance*, 89 AM. J. OF PUB. HEALTH 1328, 1329 (1999).

⁹⁶ Jo C. Phelan, Bruce G. Link, Ann Stueve, & Bernice A. Pescosolido, *Public Conceptions of Mental Illness in 1950 and 1996: What Is Mental Illness and Is It to be Feared?*, 41 J. OF HEALTH AND SOCIAL BEHAVIOR No. 2, 188, 195 (2000).

found that Americans were more likely to believe that mental illness is caused by social deviance, mental deficiency, or cognitive impairment than they were in 1950.⁹⁷ Specifically, in 1950, 7.1% of the sample described mental illness as corresponding to social deviance, while in 1996, this figure more than doubled to 15.5%.⁹⁸ Further, in 1950, 6.5% of the sample believed that mental illness corresponded to mental deficiency or cognitive impairment, while in 1996, this figure more than doubled to 13.8%.⁹⁹ Additionally, Americans in 1996 perceived people with mental illness as more frightening or violent than they did in 1950.¹⁰⁰ Specifically, in 1950, 7.2% of the sample perceived mental illness as including violent characteristics, while in 1996, this figure nearly doubled to 12.1%.¹⁰¹

Additionally, a study conducted in 1999 found “that symptoms of mental illness remain strongly connected with public fears about potential violence and with a desire for limited social interaction.”¹⁰² This study used the same nationwide survey data as the 1996 study above to determine what Americans believe to cause mental health disorders. Specifically, the study reported that that 32.8% of Americans believed that schizophrenia is “very likely” or “somewhat likely” to be caused by a person’s own bad character.¹⁰³ The study also reported that 45.1% of Americans believed that schizophrenia is “very likely” or “somewhat likely” to be caused by the way a person was raised, while 17.4% of Americans believed that schizophrenia is “very likely” or “somewhat likely” to be caused by God’s will.¹⁰⁴ Additionally, the study found that 38.2% of Americans believed that major depression is “very likely” or “somewhat likely” to be caused by a person’s own bad character.¹⁰⁵ The study also reported that 47.6% of Americans believed that major depression is “very likely” or “somewhat likely” to be caused by the way a person was raised, while 15.4% of Americans believed that major depression is “very likely” or “somewhat likely” to be caused by God’s will.¹⁰⁶

Further, the 1999 study showed that Americans associate mental illness with a propensity for violence. Specifically, the study found that 61% of Americans believed that patients with schizophrenia are “very likely” or “somewhat likely” to be violent.¹⁰⁷ The study also reported

⁹⁷ *Id.* at 195.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 196.

¹⁰¹ *Id.*

¹⁰² Link et al., *supra* note 95, at 1332.

¹⁰³ *Id.* at 1330.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ *Id.* at 1331.

that 33% of Americans believed that patients with major depression are “very likely” or “somewhat likely” to be violent.¹⁰⁸

These studies illustrate that negative stereotypes of people with mental illness remain pervasive in the U.S.. However, research has found that Americans generally prefer to avoid contact with people suffering from mental illness altogether. Specifically, the 1999 study found that 63% of Americans are “very likely” or “somewhat likely” to desire social distance from people suffering from schizophrenia.¹⁰⁹ Further, the study reported that 47% of Americans are “very likely” or “somewhat likely” to desire social distance from people suffering from major depression.¹¹⁰ Thus, it is clear that societal negative stereotypes of people with mental illness, “or stigma, lead others to avoid living, socializing, or working with, renting to, or employing people with mental illnesses.”¹¹¹

The impact of stigma on people with mental illness is powerful and often deters people from seeking treatment, prevents them from acknowledging their health problems and prevents them from disclosing their illness to others.¹¹² For example, a study conducted in 2002 found that when patients perceive negative attitudes toward their mental illness, they have a reduced likelihood of believing that they need help and are less likely to use mental health care.¹¹³ Further, other studies have found that 24% to 29% of people suffering from mental illness do not seek help because they are afraid of what people will think.¹¹⁴

Accordingly, stigma prevents patients from seeking care, which in turn affects the direct costs of mental illness. For example, approximately 40% of patients receiving antipsychotic medication do not fully comply with prescribed regimens, resulting in increased re-hospitalization and an \$800 million increase in hospital costs worldwide.¹¹⁵

Finally, stigma is also perpetuated by insurance discriminating against mental illness as “[i]t is assumed that having mental illness

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 1332.

¹¹⁰ *Id.*

¹¹¹ FRANK & GLIED, *supra* note 6, at 133.

¹¹² SURGEON GENERAL 1999, *supra* note 9, at 454. See also Patrick Corrigan, *How Stigma Interferes With Mental Health Care*, 59 AM. PSYCHOLOGIST No. 7, 614-15 (2004) (explaining that research has shown that less than 30% of people suffering from psychiatric disorders seek treatment).

¹¹³ See generally Ramin Mojtabai, et al., *Perceived Need and Help-Seeking in Adults with Mood, Anxiety, or Substance Use Disorders*, 59 ARCHIVES OF GENERAL PSYCHIATRY 77-84 (2002) (discussing 2002 study that “examined the correlates of various stages of help-seeking, including perceived need for professional help, seeking such help, and from which professionals participants sought help”).

¹¹⁴ Ronald C. Kessler, et al., *The Prevalence and Correlates of Untreated Serious Mental Illness*, HEALTH SERVS. RESEARCH 36:987-1007 (2001); Wells, et al., *Perceived Barriers to Care in St. Louis (USA) and Christchurch (NZ): Reasons for Not Seeking Professional Help for Psychological Distress*, SOCIAL PSYCHIATRY AND PSYCHIATRIC EPIDEMIOLOGY 29:155-164 (1994); see also *supra* note 95 (reporting that 24% of those without prior treatment failed to seek treatment because of what others may think).

¹¹⁵ Corrigan, *supra* note 112, at 615.

is so special that it cannot be treated with ... [all other] medical conditions.”¹¹⁶ Thus, by providing mental health parity and increased access to treatment, the stigmatization of mental illness will be reduced, benefiting mental health consumers and society by reducing the costs associated with mental illness.

IV. THE STATE APPROACH

State legislatures began to regulate the inadequacy of private insurance and mental health coverage in 1971, when Connecticut authorized the first mandated mental health parity law.¹¹⁷ In advancing parity legislation, states serve a public interest by limiting the affects of adverse selection and serve a budget interest by shifting the costs of mental health service to insurance providers.¹¹⁸ By 2006, thirty-seven states passed some form of parity legislation,¹¹⁹ and many have seen a decrease in state budgetary expenditures on mental health.¹²⁰

State legislation in the 1970s and 1980s mandated mental health benefits, but did not address minimum levels of coverage and equality between mental health and general healthcare.¹²¹ State legislation has varied by coverage, definition, and eligibility, partly because of the lack of true federal parity legislation.¹²² Some states like California have a broad definition of mental illness, which includes all disorders listed in the DSM-IV, while other states like Nevada define mental illness narrowly as a “biologically based” illness or serious mental illness (SMI).¹²³ The type of benefit mandated by state legislation is generally structured as one of three forms: mandated benefit, mandated offering and mandated-if-offered.¹²⁴ The following section will analyze state parity legislation by the type of benefit and by definition of mental illness.

¹¹⁶ ROGER KATHOL & SUZANNE GATTEAU, HEALING BODY AND MIND: A CRITICAL ISSUE FOR HEALTH CARE REFORM, 61-62 (2007).

¹¹⁷ See FRANK & GLIED, *supra* note 6, at 58 (discussing the trend for state legislatures to enact similar legislation to fulfill states’ self-interests by saving money and public interest by providing mental health coverage).

¹¹⁸ See *id.* at 51, 58 (showing, in Table 4.1, significant state expenditures in mental health services: in 2001, the states accounted for 23.4% of \$85.4 billion spent on mental health services, approximately \$20 billion).

¹¹⁹ Barry & Busch, *supra* note 31, at 1065.

¹²⁰ FRANK & GLIED, *supra* note 6, at 58.

¹²¹ Barry & Busch, *supra* note 31, at 1064-65.

¹²² *Id.*; see also U.S. DEP’T OF HEALTH & HUMAN SERVS., PUB. NO. (SMA) 03-3822, THE EFFECTS OF THE VERMONT MENTAL HEALTH AND SUBSTANCE ABUSE PARITY LAW 2, Exhibit I.1 (2003) [hereinafter Vermont Parity], available at <http://mimh200.mimh.edu/PieDb/04988.pdf>.

¹²³ *Id.* at 3 n. b (noting that narrow definitions of mental illness commonly include only “schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, schizo-affective disorder, and delusional disorder”).

¹²⁴ *Id.* at 2 n. a.

A. MANDATED BENEFIT: LEGISLATION THAT WORKS

A mandated benefit “requires insurance plans to provide coverage that meets a minimum coverage standard for mental health services” and forces mental health coverage to be made “under the same terms and conditions as the plan’s coverage for physical illnesses.”¹²⁵ Vermont and California have both enacted mandated benefit coverage.¹²⁶

1. VERMONT: A BROAD DEFINITION OF MENTAL ILLNESS

In 1998, Vermont implemented the most comprehensive parity legislation in the U.S.¹²⁷ The Vermont statute provides that a health insurance plan¹²⁸ may not create conditions that restrict access to mental health treatment that are different than access for treatment for other health conditions,¹²⁹ and provides that all deductible or out-of-pocket limits must apply equally.¹³⁰ The Vermont statute also improves treatment access by preventing insurers from excluding mental health service providers who meet the plan’s participation requirements.¹³¹ The statute also provides for a broad definition of mental illness, defining mental illness as those listed in the mental disorders section of the International Classification of Diseases, which is similar to the DSM.¹³²

In 2003, the U.S. Department of Health and Human Services (DHHS) evaluated how the Vermont mental health parity laws affected employers, the state’s largest insurers, and consumers.¹³³ DHHS found that parity did not cause employers to drop health coverage or switch to self-insured products.¹³⁴ Only 0.3% of employers dropped coverage due to parity legislation, affecting only 0.07% of all employees, while an insignificant number of employers avoided parity by switching to self-insurance.¹³⁵ These results are consistent with the inverse relationship between mental health and general health spending, and support the finding that parity does not increase overall costs to employers and society.¹³⁶

¹²⁵ Kaplan, *supra* note 1, at 351.

¹²⁶ Vermont Parity, *supra* note 122, at 2 Exhibit I.1.

¹²⁷ *Id.* at ix; see also Kaplan, *supra* note 1, at 338.

¹²⁸ VT. STAT. ANN. tit. 8, § 4089b(b)(1) (West 2011) (defining health insurance plan as “any health insurance policy or health benefit plan offered by a health insurer . . . [or] any health benefit plan offered or administered by the state, or any subdivision or instrumentality of the state.”).

¹²⁹ *Id.* § 4089b(c) (mandating benefit parity between general healthcare, and mental healthcare).

¹³⁰ *Id.* § 4089b(c).

¹³¹ *Id.* § 4089b(c)(3).

¹³² *Id.* § 4089b(b)(2).

¹³³ Vermont Parity, *supra* note 122, at ix.

¹³⁴ *Id.* at 57.

¹³⁵ *Id.* (indicating that only 8% of Vermont’s employees switch to a self-insured plan after parity was implemented, but only 3% of those that switched did so as a result of parity).

¹³⁶ *Id.* See also discussion *supra* Part IV.C (discussing how mental health parity reduces direct and indirect costs borne by employers and society as a whole).

Mental health consumers in Vermont have obtained greater access to treatment as a result of parity.¹³⁷ In Vermont, two major health plans, Kaiser/Community Health Plan (Kaiser) and Blue Cross Blue Shield of Vermont (BCBS), represented 80% of the privately insured population when parity was enacted.¹³⁸ However, after parity was introduced in Vermont, mental health consumers were 18% to 24% more likely to obtain mental health services through the Kaiser and BCBS plans.¹³⁹ Unfortunately, BCBS prevented parity by carve-out practices, which reduced access to treatment and the average number of outpatient visits.¹⁴⁰ Further, Kaiser mental health consumers experienced a 32% reduction in their chance of receiving inpatient care as Kaiser increased the use of alternative programs instead of hospitalization.¹⁴¹ Overall, however, the average number of outpatient visits increased and “parity improved access to and intensity of outpatient mental health services among many health plan members in Vermont.”¹⁴²

After the enactment of parity, Vermont mental health consumers paid smaller amounts of the total direct cost of mental health spending.¹⁴³ BCBS consumer cost sharing fell from 27% to 16%.¹⁴⁴ In general, mental health consumers saw reductions in cost sharing as a result of increased access to outpatient services.¹⁴⁵ Despite the overall increased access to treatment, overall spending on mental health services declined by up to 18%.¹⁴⁶ Spending rose 4.4% for BCBS, or \$2.32 annually per member, while spending declined by 9% at Kaiser.¹⁴⁷

Mental health parity has been largely accomplished in Vermont. However, full parity has not been realized because a federal loophole remains that enables employers to avoid parity laws by switching to self-insurance.¹⁴⁸ This federal loophole will be considered in Section VI.

2. CALIFORNIA: A LIMITED DEFINITION OF MENTAL ILLNESS

The California legislature has considered parity legislation since the 1980s and in 1999 became the twenty-fifth state to adopt parity after

¹³⁷ See Vermont Parity, *supra* note 122, at 58 (noting “the average number of outpatient visits per user increased as well”).

¹³⁸ See *id.* at 57-58 (discussing increased access to mental health care due to coverage by the two providers).

¹³⁹ See *id.* (“The likelihood of obtaining mental health services rose between 18 and 24 percent in the two health plans as a result of parity.”).

¹⁴⁰ See *id.* at 58 (“[F]or BCBSVT members who received their MH/SA benefits through the carve-out, the use of managed care arrangements offset the effect of parity.”).

¹⁴¹ See *id.* (noting reduced chance of in-patient care under the Kaiser mental health plan).

¹⁴² See *id.* (noting overall increased access to mental health care through parity).

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ See *id.* at 59. See also *infra*, Section VI.

enacting Assembly Bill 88 (A.B. 88).¹⁴⁹ A.B. 88 mandates that health insurance policies must provide coverage benefits for severe mental illnesses.¹⁵⁰ A.B. 88 mandates that financial terms and conditions must be applied equally to mental and general health, including maximum lifetime benefits, co-payments and deductibles.¹⁵¹

The mandated portions of California's parity legislation are similar to that of Vermont.¹⁵² However, A.B. 88 defines mental illness as SMI.¹⁵³ State classification of SMI vary, but A.B. 88's definition of SMI includes schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.¹⁵⁴ This list is a more restrictive definition of mental illness than the DSM-IV and created opposition among parity proponents.¹⁵⁵

The goal of A.B. 88 is to improve quality and access to mental health services for people with SMI.¹⁵⁶ In 2001, after parity in California went into effect, the California HealthCare Foundation published an early evaluation.¹⁵⁷ After intervening sixty stakeholders¹⁵⁸ throughout the state, the study found that "[a]t a minimum, there is widespread agreement that health insurance benefits for mental health services have been expanded" and that parity did not have an adverse consequence on health insurance markets.¹⁵⁹

¹⁴⁹ CAL. DEP'T OF MENTAL HEALTH, MENTAL HEALTH PARITY-BARRIERS AND RECOMMENDATIONS 3 (2005) [hereinafter BARRIERS AND RECOMMENDATIONS].

¹⁵⁰ 1999 Cal. Assemb. B. 88 (adopted on September 27, 1999 and became effective January 1, 2000 by addition of section 1374.72 to the Health and Safety Code and section 10144.5 to the Insurance Code) [hereinafter 1999 Cal. AB 88]. Specifically, Assembly Bill 88 mandates benefits for outpatient services, in-patient hospital services, partial hospital services, and prescription drugs. Assembly Bill 88 is a mandated-benefit statute but provides that prescriptions drugs must be offered in parity "if the plan contract includes coverage for prescription drugs[,] a mandate-if-offered provision.

¹⁵¹ *Id.*

¹⁵² Compare 1999 Cal. AB 88, with 8 VT. STAT. ANN. TIT. 8 § 4089b(c) (both employing an aggressive mandated-benefit structure).

¹⁵³ 1999 Cal AB 88.

¹⁵⁴ *Id.* (1999 Cal. AB 88 also provides additional parity protections for children with serious emotional disturbances).

¹⁵⁵ Assembly Health Committee, California Legislative Bill History, 1999 Legis. Bill Hist. 1999 Cal. Assemb. B. 88 (noting that while the although the CA Psychological Association supported Assembly Bill 88, it argued that all mental illnesses should be included and sponsored a rival bill).

¹⁵⁶ BARRIERS AND RECOMMENDATIONS, *supra* note 149, at 3 (stating that the parity legislation also intended to decrease the economic burden on the public, end discrimination, and reduce "the stigma associated with mental illness and the delivery of mental health services").

¹⁵⁷ See TIMOTHY LAKE ET AL., MATHEMATICS POLICY RESEARCH, INC., A SNAPSHOT OF THE IMPLEMENTATION OF CALIFORNIA'S MENTAL HEALTH PARITY LAW, vii, 3 (February 20, 2002) ("[t]he study's purpose was to assess the perceived objectives, initial experiences, and anticipated outcomes of the new law after its first year of implementation.").

¹⁵⁸ See *id.* at 3 (including government officials, health plan representatives, employers, providers and mental health consumers).

¹⁵⁹ See *id.* at 23 (discussing the assessment of the first year of implementation of parity).

There is some empirical evidence that mental health consumers received greater access to treatment post parity enactment. A 2002 case study of two large California employers revealed that for one employer, Employer B, consumers experienced a 24.1% increase in outpatient utilization, an 11.4% increase in inpatient utilization and a 17.5% increase in intermediate care utilization.¹⁶⁰ However with Employer A, consumers experienced a 24.7% decrease in outpatient utilization, a 33.9% decrease in inpatient utilization and a 54.3% decrease in intermediate care utilization.¹⁶¹ Although we generally expect an increase in benefits to result in increased utilization,¹⁶² Employer A operated under managed care, where moral hazard and adverse selection do not control the responsiveness of consumer demand.¹⁶³ Accordingly, the demand curve for A's generous health plan is less responsive and, unlike Employer B, will not necessarily result in increased utilization.¹⁶⁴

The study also showed that parity legislation does not result in undue increases in overall spending for employers. Employer A experienced a 1.9% decrease in total expenditure per member per year.¹⁶⁵ Employer B, who was not operating under a managed care system, experienced a 23.1% increase in total expenditure per member per year.¹⁶⁶ Initially, a large increase seems to demonstrate that mental health parity will cause a rapid rise in healthcare costs; however the \$12 increase in spending per member "was well under 1 percent of total healthcare spending for employer B."¹⁶⁷ Additionally, California parity laws do not include a cost increase exemption, such as the one percent cost increase exemption in federal legislation.¹⁶⁸ However, if California had included a cost increase exemption, neither employer would have been eligible. Thus, the study shows two principles in effect in California: first, parity legislation increases access to care; and second, parity legislation does not result in an undue burden on insurers, who

¹⁶⁰ See Robert B. Branstrom & Roland Sturm, *Economic Ground Rounds: An Early Case Study of the Effects of California's Mental Health Parity Legislation*, 53:10 PSYCHIATRIC SERV. 1215, 1215-16 (2002) [hereinafter Branstrom & Sturm] ("describ[ing] the experience of two large employer groups in California that implemented parity in mental health benefits on January 1, 2001, under plans provided through a managed behavioral health organization (MBHO)").

¹⁶¹ See *id.* at 1215 (citing Table 1).

¹⁶² See *supra* note 23 and accompanying text (noting that as spending on mental health care rises, utilization of facilities and services increases).

¹⁶³ See Barrett, *supra* note 28, at 1169-70 (discussing the incapability of moral hazard and adverse selection to parity in the era of managed care).

¹⁶⁴ Branstrom & Sturm, *supra* note 160, at 1215.

¹⁶⁵ *Id.* at 1216.

¹⁶⁶ *Id.* This figure is significant, but certainly not unexpected when considering that moral hazard and adverse selection remained in play in a plan without managed care.

¹⁶⁷ *Id.*

¹⁶⁸ RAMYA SUNDARARAMAN & C. STEPHEN REDHEAD, CONG. RESEARCH SERV., RL 33820, THE MENTAL HEALTH PARITY ACT: A LEGISLATIVE HISTORY 15 (2007) [hereinafter CRS HISTORY].

may actually experience a decline in overall spending.¹⁶⁹

Despite parity legislation, the California Department of Mental Health has found that barriers remain to prevent achievement of mental health parity.¹⁷⁰ The largest barrier to parity has been the difficulty that mental health consumers face in obtaining understandable information about policies, procedures and routine mental health services.¹⁷¹ Further, the goal of reducing the effects of social stigma has yet to be attained.¹⁷² Despite the implementation of a parity structure, the need for mental health services is still viewed with skepticism.¹⁷³ Although parity may have been accomplished on paper in California, there is more work to be done to fully implement parity.¹⁷⁴

B. WEAKER POLICY FORMATIONS OF MENTAL HEALTH PARITY LEGISLATION

Besides mandated benefit parity legislation, states use two policy formulations that offer less protection than full parity.¹⁷⁵ First, a mandated offering parity statute requires insurance providers to offer optional mental health coverage to consumers, which may include additional premiums.¹⁷⁶ A mandated offering is less than full parity because mental health consumers still bear additional costs of optional mental health insurance.

Utah mental health parity legislation is a mandated offering statute, which requires insurers to offer employers with fifty-one employees or more, an insurance plan with no mental health coverage and an insurance plan with mental health coverage with lifetime, annual, and out-of-pocket limits in parity with general health.¹⁷⁷ However, Utah does not regulate cost sharing mechanisms before lifetime maximums are met.¹⁷⁸ Utah defines mental illness by DSM-IV, but specifically excludes personality disorders, psychosexual disorders, learning disabilities and mental retardation.¹⁷⁹ Although parity is limited in

¹⁶⁹ Branstrom & Sturm, *supra* note 160, at 1215-16.

¹⁷⁰ BARRIERS AND RECOMMENDATIONS, *supra* note 149, at 16.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

¹⁷⁴ *Id.* at 6.

¹⁷⁵ CRS HISTORY, *supra* note 168, at 15.

¹⁷⁶ Kaplan, *supra* note 1, at 352. These statutes also vary by how mental illness is defined. For instance, Georgia has enacted a mandated-offering statute based on a broad DSM-IV definition of mental illness while Nebraska's mandated-offering statute defines mental illness by SMI. CRS History, *supra* note 168, at 15.

¹⁷⁷ UTAH CODE ANN. § 31A-22-625 (West 2011) (mandating that insurers must offer plans with catastrophic mental health coverage, or coverage above the statutory minimum, no coverage plans, and 50/50 plans to employers with two to fifty employees).

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* (noting that Utah also excludes diagnoses related to marital and family problems as well as diagnoses that are a result of "social, occupational, religious, or other social maladjustment").

Utah, two years after its enactment in 2000, Utah saw only a 0.9% increase in mental health expenditures due to parity, while access to mental health services generally increased.¹⁸⁰

Unfortunately, because Utah has a mandated offering statute, employers have the ability to avoid offering mental health coverage by selecting a plan with no mental health benefits. In fact, the Utah Insurance Department found that since the enactment of parity, some employers have exploited this loophole and have reduced or eliminated mental health coverage for their employees.¹⁸¹ Under any mandated offering parity legislation employers have the ability to avoid providing mental health coverage and defeat the purpose of the law.

Second, parity legislation is also constructed as a mandated-if-offered statute. These statutes require that if an employer offers mental health benefits, then coverage must be in parity with general health.¹⁸² A mandated-if-offered statute offers the least parity protection because it allows employers and insurers the opportunity to avoid parity by providing no mental health coverage at all.¹⁸³ Accordingly, legislatures should not consider a mandated offering or a mandated-if-offering statute in future parity legislation because neither can achieve full parity.

V. THE FEDERAL APPROACH & ERISA PREEMPTION

Prior to the enactment of the Employee Retirement Income Securities Act of 1974 (“ERISA”) a state solution to mental health discrimination was at least possible. However, ERISA provided large multi-state employers the right to self-insure and avoid state parity legislation.¹⁸⁴ ERISA regulates pensions and “employee welfare plans” by establishing judicial remedies, claim procedures, mandatory information disclosure, and standards for benefits plan administrators.¹⁸⁵

The primary objective of Congress in enacting ERISA was to provide (1) protection of interstate commerce; (2) protect the interests of participants and beneficiaries of employee benefit plans; and (3)

¹⁸⁰ UTAH INS. DEP’T, 2004 CATASTROPHIC MENTAL HEALTH REPORT, 14-15 (February 27, 2004).

¹⁸¹ *Id.* at 19.

¹⁸² See Kaplan, *supra* note 1, at 353 (showing these statutes also vary by how mental illness is defined); see also CRS History, *supra* note 168, at 14 (discussing, generally, results found in Table B: Comparison of FEHB and State Parity Laws).

¹⁸³ See Kaplan, *supra* note 1, at 352 (stating mandated-if-offered statutes require “an employer to provide equal coverage for mental health services and other medical services if the employer offers mental health coverage. The employer can omit from its plan insurance coverage for mental health as a way of avoiding the statute’s requirements.”).

¹⁸⁴ See GERALD N. GROB & HOWARD H. GOLDMAN, THE DILEMMA OF FEDERAL MENTAL HEALTH POLICY: RADICAL REFORM OR INCREMENTAL CHANGE? 167 (2006) (noting self-insured employer health plans are not required to follow state parity law).

¹⁸⁵ See Elizabeth S. Boison, *Mental Health Parity for Children and Adolescents: How Private Insurance Discrimination and ERISA Have Kept American Youth From Getting the Treatment They Need*, 13 AM. U.J. GENDER SOC. POL’Y & L. 187, 200-01 (2005) (discussing how federal law has undermined states’ efforts to provide mental healthcare to children and teens).

to establish uniform standards for the administration of employee benefit plans.¹⁸⁶ To achieve these goals, Congress provided that ERISA standards would preempt state regulation of employee benefit plans.¹⁸⁷

Through preemption, ERISA applies through a two-tier system. First, the ERISA savings clause, exempts all state laws that regulate insurance from preemption.¹⁸⁸ However, the ERISA deemer clause prevents state insurance law from regulating self-insured employment health benefit plans.¹⁸⁹ Thus under this two-tiered system employment health benefit plans must comply with state and federal parity legislation, however, self-insured employment health benefit plans are exempt from state legislation through ERISA preemption.¹⁹⁰

Since the enactment of ERISA, there has been a trend of employers shifting to self-insured health plans. For instance, a study reported that two years after ERISA was enacted only 4% of employee health benefits were self-insured plans.¹⁹¹ However, the study found that in 1986, 47% of employee health benefits were self-insured plans.¹⁹² Another study found that in 1992, 67% of employee health benefits were self-insured plans.¹⁹³ While in 2003, "fifty-two percent of workers with employment-based health care benefits were in self-insured plans."¹⁹⁴

These studies demonstrate a strong correlation between the use of self-insured plans and the enactment of ERISA.¹⁹⁵ "Still, it seems clear that at least some and probably much of the increase in self-insurance can be attributed to the desire to use ERISA to avoid state regulations of one type or another."¹⁹⁶ Thus, ERISA has limited the states' ability to create mental health parity through legislation. Accordingly, federal legislation is the only means available to ensure equal access to mental health care.¹⁹⁷

¹⁸⁶ 29 U.S.C. § 1001(b).

¹⁸⁷ See Boison, *supra* note 185, at 198-199 (discussing preemption under ERISA); see also 29 U.S.C. § 1144 (stating a state law may be preempted by a federal law either by implied preemption, field preemption, or express preemption; notably, ERISA is an express preemption of state law); see also 29 U.S.C. § 1144(a); Beverly N. Rich, *Tracking AB 540's Potential Resilience: An Analysis of In-State Tuition for Undocumented Students in Light of Martinez v. Regents of the University of California*, 19 S. CAL. REV. L. & SOC. JUST. 297, 309 (2010) (providing an introduction to the federal preemption doctrine).

¹⁸⁸ See 29 U.S.C. § 1144(b)(2)(A).

¹⁸⁹ See *id.* § 1144(b)(2)(B).

¹⁹⁰ Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 110 (2005).

¹⁹¹ Steve Kalmeyer, *ERISA and State Health Reform*, HEALTH POL'Y MONITOR, Spring 1997, at 1.

¹⁹² Korobkin, *supra* note 190, at 108.

¹⁹³ *Id.* (citing A. Foster Higgins & Co., FOSTER HIGGINS HEALTH CARE BENEFITS SURVEY 19 (1992)).

¹⁹⁴ *Id.* at 109.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ See GROB & GOLDMAN, *supra* note 184.

A. THE MENTAL HEALTH PARITY ACT OF 1996: THE FIRST STEP

In 1992, Senator Paul Wellstone and Senator John Danforth introduced the first mental health parity legislation.¹⁹⁸ Although the bill was not enacted, it sparked debate in Congress and subsequently the Clinton administration included parity provisions in the Clinton healthcare reform package.¹⁹⁹ Mental health parity did not gain momentum until Senator Wellstone and Senator Pete Domenici prominently placed the issue in the public agenda, as both Senators had mental illness in their families.²⁰⁰ The Senators co-sponsored the Mental Health Parity Act of 1996 (MHPA), which required parity for annual and lifetime dollar limits for group health plans of at least twenty-six employees.²⁰¹ However, MHPA was a mandated-if-offered statute that would only apply the parity provisions to group health plans that chose to provide mental health coverage.²⁰²

MHPA was enacted as an amendment to the 1997 VA-HUD appropriations bill and was approved by the Senate after the addition of a one percent cost increase exemption and after a small business exception was changed to fifty employees.²⁰³ MHPA did not apply to the eighty million employees and dependents in small group plans²⁰⁴ nor did it apply to self-insured plans covered by ERISA.²⁰⁵ Due to ERISA, MHPA failed to prevent large multi-state employers from switching to self-insured plans to avoid parity.²⁰⁶ This limitation prevented mental health parity for over sixty-five million Americans enrolled in self-insured plans.²⁰⁷ Moreover, MHPA did not stop insurers from blocking access to services through cost sharing provisions like increased co-payments and out-of-pocket burdens on mental health consumers.²⁰⁸

After MHPA went into effect in 1998, the Government Accounting Office determined that insurers were not in full compliance with the law because insurers were circumventing the parity provisions by placing restrictions and conditions on mental health consumers.²⁰⁹ MHPA did not accomplish true parity, but it was received as a step in the right direction by providing mental health consumers some protection from

¹⁹⁸ Equitable Health Care for Severe Mental Illnesses Act of 1992, S. 2696, 102d Cong. (1992).

¹⁹⁹ CRS HISTORY, *supra* note 168, at 3.

²⁰⁰ Sheryl Gay Stolberg, *Breaks for Mental Illness: Just What the Government Ordered*, N.Y. TIMES, May 4, 1997, at 4.

²⁰¹ Mental Health Parity Act of 1996, § 702, 29 U.S.C. § 1185a (2006).

²⁰² *Id.*

²⁰³ CRS HISTORY, *supra* note 168, at 3; *see also* Dep't of Veterans Affairs and Hous. and Urban Dev., and Independent Agencies Appropriations Act, Pub. L. No. 104-204, 110 Stat 2874 (1996).

²⁰⁴ DHHS 1997, *supra* note 11, at 7.

²⁰⁵ KELLY, *supra* note 45, at 101.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ GROB & GOLDMAN, *supra* note 184, at 167.

²⁰⁹ *Id.* at 168.

financial ruin.²¹⁰

B. THE MENTAL HEALTH PARITY & ADDICTION EQUALITY ACT OF 2008: AN INCOMPLETE STEP

MHPA included a sunset provision that allowed the law to expire in 2001 unless renewed by Congress.²¹¹ Congress reauthorized MHPA yearly, but attempts to broaden its scope have failed.²¹² Although “[f]ederal employees and Members of Congress, have had equal access to mental health and addiction services since 2001[.]”²¹³ mental health consumers waited over a decade for Congress to expand the scope of federal parity legislation. On October 3, 2009, under the auspicious of a \$700 billion economic bailout package, President George Bush signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”).²¹⁴ MHPAEA took effect on January 1st, 2010²¹⁵ and was received with praise despite substantial limitations.²¹⁶

MHPAEA expands parity protections offered by MHPA by requiring equal terms and conditions between mental and general health.²¹⁷ Since MHPAEA was enacted as a section of ERISA, it reaches far more mental health consumers than did MHPA and closes the self-insured loophole.²¹⁸ MHPAEA prevents discrimination against mental health consumers by mandating parity for treatment limitations and cost sharing provisions.²¹⁹ Specifically, it requires that group health plans providing mental health coverage may not establish more restrictive requirements or separate cost sharing requirements for mental health.²²⁰ The bar on cost sharing discrimination includes deductibles, co-payments, coinsurance, and out-of-pocket expenses.²²¹

MHPAEA also protects mental health consumers from unequal treatment limitations²²² by specifically mandating parity for “frequency of treatment, number of visits, days of coverage, or other similar limits

²¹⁰ See also KELLY, *supra* note 45, at 9-10; GROB & GOLDMAN, *supra* note 184; Barrett, *supra* note 28, at 1177-78.

²¹¹ Mental Health Parity Act of 1996, § 702, Pub. L. No. 104-204, *codified at* 29 U.S.C. § 1185a (2006); see also GROB & GOLDMAN, *supra* note 184, at 168.

²¹² CRS HISTORY, *supra* note 168, at 7-11.

²¹³ 154 CONG. REC. E1401 (2008) (speech of Rep. Patrick J. Kennedy).

²¹⁴ Tammy Worth, *Mental Health Coverage Gets Shot at Parity*, L.A. TIMES, October 13, 2008, at F3.

²¹⁵ *Id.*

²¹⁶ See, e.g., Rosslyn Carter & Betty Ford, *Mental Health Legislation We Need*, WASH. POST, at A18 (September 19, 2008).

²¹⁷ 29 U.S.C. § 1185a(a)(3).

²¹⁸ See KELLY, *supra* note 45, at 102 (noting that the Act had bipartisan support to close the ERISA exception to parity).

²¹⁹ 29 U.S.C. § 1185a(a)(3) (1996).

²²⁰ *Id.* § 1185a(a)(3)(A).

²²¹ *Id.* § 1185a(a)(3)(B)(i).

²²² *Id.* § 1185a(a)(3)(A)(ii).

on scope or duration of treatment.”²²³ Treatment limitation parity was a major victory for mental health consumers as insurers have traditionally used cost shifting mechanisms to avoid MHPA parity mandates.²²⁴

MHPAEA does not offer full parity because it is a mandated-if-offered statute, the weakest form of parity law.²²⁵ MHPAEA provides that if an employer offers mental health coverage, any financial requirements and treatment limitations must be “no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan.”²²⁶ As of 2007, six states (Arizona, Florida, Iowa, Kentucky, Louisiana and Nebraska), had mandated-if-offered parity legislation.²²⁷ However, research has shown that mandated-if-offered parity legislation has no statistically significant effect on admissions and no significant reduction of the probability that an admitted mental health patient is uninsured.²²⁸ Thus, the MHPAEA, like state mandated-if-offered legislation, cannot achieve full parity.

1. EXEMPTIONS, LIMITATIONS, AND DEFINITIONS

Although MHPAEA retained the parity requirements for lifetime and annual caps from the MHPA,²²⁹ it also contains several exceptions. Specifically, MHPAEA retained the small business exception, which excludes businesses of fifty employees or less from parity.²³⁰ However, due to this one exemption alone, the MHPAEA does not cover over forty-five million employees who work for businesses with less than fifty employees.²³¹ For instance, the Department of Labor reports that in March of 2008, over forty-nine million people were employed by businesses with less than fifty employees.²³² In any given year approximately 20% of Americans suffer from a mental disorder, while 15% of the adult population uses mental health services.²³³ Further,

²²³ *Id.* § 1185a(a)(3)(B)(ii).

²²⁴ See GROB & GOLDMAN, *supra* note 184, at 167.

²²⁵ Kaplan, *supra* note 1, at 352.

²²⁶ Mental Health Parity and Addiction Equity Act of 2008, H.R. 1424, 110th Cong. § 512a(a)(1) (2008) (codified as amended at 29 U.S.C. § 1185a).

²²⁷ Dave Dhaval & Mukerjee Swati, *Mental Health Parity Legislation, Cost-Sharing and Substance-Abuse Treatment Admissions*, 20 HEALTH ECON. 161, 179 (2011).

²²⁸ *Id.* at 180.

²²⁹ 29 U.S.C. § 1185a(a)(1)-(2) (mandating parity for lifetime and annual policy limits for small group health plans that also provide mental health coverage).

²³⁰ *Id.* § 1185a(c)(1).

²³¹ Bureau of Labor Statistics, U.S. DEP’T OF LABOR, QUARTERLY CENSUS OF EMP’T AND WAGES, available at <http://www.bls.gov/cew/> (last visited May 13, 2011). Since 2005, small businesses with less than forty-nine employees employed over forty-five million people annually. 2010 data is preliminary. Data on file with author. See Appendix 1.

²³² *Id.*

²³³ Karla Balling, *A Family Impact Analysis of the Family Mental Health Parity Act*, in Family Impact Analysis Series, POLICY INST. FOR FAMILY IMPACT SEMINARS (2003) available at http://www.familyimpactseminars.org/fia_analyses_fpmhp.pdf.

the National Institute of Mental Health reported that in 2008, the prevalence of serious mental illness in the U.S. was over 4%.²³⁴ Thus, as a result of the small business exemption it is certain that millions of people affected by mental illness are outside the scope of MHPAEA.

MHPAEA also retained a cost-increase exemption similar to MHPA.²³⁵ Specifically, if mental health parity results in a cost increase of two percent in the first year of implementation, then the insurer may claim an exemption.²³⁶ Additionally, an insurer may also be exempt of it has a one percent cost increase in any subsequent year.²³⁷

If such a cost is incurred, the plan is exempt for the plan year following the year the cost was incurred. Thus, the exemption lasts one year. After that, the plan is required to comply again; however, if the plan incurs an increased cost of at least one percent in that plan year, the plan could claim the exemption for the following plan year.²³⁸

However, the Department of Labor's interim final regulations to implement MHPAEA do not provide any guidance for implementing the increased cost exemption.²³⁹ Thus, until future regulatory guidance is given, insurers seeking to claim the cost-increase exemption must follow the exemption procedures provided by the Department of Labor to implement MHPA regulations.²⁴⁰ Accordingly, insurers seeking to apply for cost increase exemption must demonstrate that the cost increase was directly a result of the implementation of MHPAEA.²⁴¹ Further, applicants for a cost exemption must demonstrate that the increased cost was not a result of "trends in utilization and prices, a random claims experience that is unlikely to persist, or seasonal variation typically experienced in claims submission and payment patterns."²⁴² Finally, if an exemption is given, then the insurer is subject to government audits.²⁴³

However, MHPAEA is also susceptible to insurers avoiding parity

²³⁴ NIMH, Prevalence of Serious Mental Illness Among U.S. Adults by Age, Sex, and Race, available at http://nimh.nih.gov/statistics/SMI_AASR.shtml.

²³⁵ 29 U.S.C. § 1185a(c)(2).

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ DEP'T OF LABOR, FAQ'S ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART V AND MENTAL HEALTH PARITY IMPLEMENTATION, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> (stating that small employers remain exempt from MHPAEA even after the passage of the PPACA).

²³⁹ *Id.*

²⁴⁰ *Id.* See also Interim Rules for Mental Health Parity, 62 Fed. Reg. 66932, (Dec. 22, 1997).

²⁴¹ 62 Fed. Reg. 66932, (Dec. 22, 1997).

²⁴² DEP'T OF LABOR, *supra* note 238.

²⁴³ 29 U.S.C. § 1185a(c)(2).

because the law does not provide a provision to monitor compliance.²⁴⁴ Monitoring compliance is necessary as insurance companies have proven to be creative in establishing new means of restricting access to mental health care. For instance, insurers have attempted to discourage mental health providers from participating in mental health plans by making reimbursement more difficult.²⁴⁵

Determining how to define mental illness has been an area of contention throughout the development of all mental health parity legislation.²⁴⁶ MHPAEA avoided the conflict with insurers by giving the insurer the authority to define mental illness.²⁴⁷ Some advocates of parity mistakenly assume that the definition of mental illness is based on serious mental illness, since DSM-IV is not used to define mental illness in MHPAEA.²⁴⁸ However, MHPAEA specifically provides that mental health conditions are “defined under the terms of the plan or coverage.”²⁴⁹ Thus, employers and insurers can arbitrarily cherry pick²⁵⁰ the mental illnesses they will provide coverage for, if any, and defeat mental health parity entirely.

MHPAEA is a step in the right direction; however it has left several options available for insurers and employers to avoid implementation. Moreover, as a mandated-if-offered statute, MHPAEA falls far short of full parity.

C. THE PATIENT PROTECTION & AFFORDABLE CARE ACT

In 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA)²⁵¹ and the Health Care and Education Reconciliation Act (HCERA).²⁵² The PPACA, as modified by the HCERA, takes some steps towards extending the reach of federal parity law. The Congressional intent behind the PPACA is to provide

²⁴⁴ Barrett, *supra* note 28, at 1180 (discussing shortcomings of the Mental Health Parity & Addiction Equality Act of 2008).

²⁴⁵ *Id.* (explaining that some insurance companies have made reimbursement so hard to navigate that mental-health professionals have dropped insurance plans that provide comprehensive mental-health benefits).

²⁴⁶ See e.g., John C. Goodman & Wess Mitchell, *The Case Against Mental Health Parity, Part III: Does the Care Really Work?*, Brief Analysis No. 412, NAT'L CTR. FOR POLICY ANALYSIS 1 (2002) (criticizing any definition of mental illness based on DSM).

²⁴⁷ See 29 U.S.C. § 1185a(e)(4).

²⁴⁸ See KELLY, *supra* note 45, at 102 (stating that since DSM-IV has been dropped from the Act “it is more likely that ‘parity’ coverage will be extended on a priority basis to those with serious mental illness”).

²⁴⁹ See 29 U.S.C. § 1185a(e)(4).

²⁵⁰ See Schmall, *supra* note 66, at 665 (discussing that employers may “exclude illnesses based on stereotypes, false assumptions, or costs ... [while] overestimate[ing] the cost of providing mental health insurance”).

²⁵¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter PPACA].

²⁵² Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter HCERA].

health insurance to almost all U.S. citizens and legal immigrants by 2014. In providing this coverage Congress also expanded insurance coverage to millions of Americans suffering from mental illness and substance abuse disorders.²⁵³

As previously discussed, federal mental health parity law prior to PPACA did not include a mandate for mental health insurance coverage; rather federal legislation general required that when a benefit is offered it must be offered in parity, known as “mandated-if-offered” statutes. However, the PPACA is the first federal legislation to create a coverage mandate for mental health and substance abuse services.

Specifically, the PPACA provides that qualified health plans, certain Medicaid benchmark and benchmark-equivalent plans and plans offered through the individual market must provide an essential health benefits package. The PPACA defines essential health benefits broadly through ten general health care categories that include “mental health and substance use disorder services, including behavioral health treatment.”²⁵⁴ The PPACA does not specify what services are included in the essential health benefits categories, but the act provides that the scope of the essential health benefits should be equal to the benefits typically provided in an employer’s health insurance plan.²⁵⁵ The PPACA also provides additional guidance and definitions for the three plan types affected by the essential health benefits mandate.

1. QUALIFIED HEALTH PLANS (QHPs)

The PPACA defines qualified health plans as a properly certified plan that is issued or recognized by each exchange which offer the plan; that provides essential health benefits as described in the PPACA; and is offered by a licensed health insurance insurer.²⁵⁶ Qualified health plans that meet the statutory requirements of PPACA are required to include the essential health benefits package,²⁵⁷ which will extend mental health coverage to many Americans. However, this section alone does not mandate full parity because the PPACA does not specify what health care services must be included in the essential health benefits package.

²⁵³ See Brian Kopp, et al., *New Federal Health Care Reform Legislation—Its Impact on Employers and Employee Benefits Plans*, 2010 Emerging Issues 4954 (discussing expanded coverage under the Patient Protection & Affordable Care Act).

²⁵⁴ See PPACA § 1302(b) (2011) (explaining that essential health benefits include: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care).

²⁵⁵ See *id.*

²⁵⁶ See *id.* § 1301.

²⁵⁷ See *id.* § 1301(a)(1)(B).

2. CERTAIN MEDICAID BENCHMARK & BENCHMARK-EQUIVALENT PLANS

Medicaid is a federal entitlement program that is operated by the individual states.²⁵⁸ To be eligible for Medicaid, an applicant must meet certain group categorical and income requirements.²⁵⁹ Some groups are mandatory and must be accepted by the states, including “pregnant women, and poor individuals with disabilities or poor individuals over age 64 who qualify for cash assistance under the Supplemental Security Income (SSI) program.”²⁶⁰ However, other groups are not mandatory, including pregnant women with an income between 133% and 185% of the federal poverty level.²⁶¹

Medicaid plans are offered through traditional state benefit plans or state specified benchmark or benchmark-equivalent plans.²⁶² Either of these options may be provided as a managed care plan or a non-managed care plan. Under federal law enacted prior to the PPACA, all Medicaid managed care plans that provide both medical and surgical benefits and mental health or substance use disorder benefits must meet federal parity requirements.²⁶³

The PPACA expands Medicaid parity requirements by addressing the lack of parity in managed care Medicaid benchmark and benchmark-equivalent plans. Specially, the PPACA provides that managed care Medicaid benchmark and benchmark-equivalent plans must provide the essential health benefits package,²⁶⁴ including “mental health and substance use disorder services.”²⁶⁵

The PPACA also expands mental health parity to certain non-managed care benchmark and benchmark-equivalent plans that offer both medical and surgical benefits as well as mental health or substance use disorder benefits.²⁶⁶ However, for these non-managed care plans, the PPACA only extends parity for treatment limitations and financial requirements.²⁶⁷ Congress has defined treatment limitations as “limits on the frequency of treatment, number of visits, days of coverage, or

²⁵⁸ See Julie Stone, CONG. RESEARCH SERV., MEDICAID AND THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) PROVISIONS IN PPACA: SUMMARY AND TIMELINE 4 (2010) (discussing the PPACA’s changes to Medicaid eligibility).

²⁵⁹ See *id.* (including children, pregnant women, families with dependent children, elderly, or disabled).

²⁶⁰ See *id.* (discussing mandatory groups, which states must cover under Medicaid).

²⁶¹ See *id.* (discussing optional eligibility groups, which states may choose to cover under Medicaid).

²⁶² *Id.* at 17.

²⁶³ Social Security Act § 1932(b)(8), *codified at* 42 U.S.C. § 1396u-2 (2010) [hereinafter SSA].

²⁶⁴ PPACA § 2001(c)(3).

²⁶⁵ PPACA § 1302(b).

²⁶⁶ PPACA § 2001(c)(3).

²⁶⁷ *Id.*

other similar limits on the scope or duration of treatment.”²⁶⁸ While financial requirements are defined as “deductibles, co-payments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit.”²⁶⁹

The PPACA does advance mental health parity overall through the inclusion of mental health and substance abuse within the mandated essential health benefits; however, the impact of the essential health benefits package is currently unclear because their scope has yet to be defined through the rulemaking process.²⁷⁰

3. INDIVIDUAL & SMALL GROUP MARKET PLANS

The PPACA also requires new individual and small group market plans to include essential health benefits.²⁷¹ Requiring the essential health benefits package, which includes mental health and substance abuse coverage, is a significant step. However, the PPACA also continues the MHPAEA small employer exception for businesses with less than fifty employees, which limits the expansion of parity.²⁷²

Further, in some instances the PPACA even expands the reach of the small business exception by modifying the definition of small employer. Specifically, for group plans, which are nonfederal government plans, the definition of small employer was amended to mean “an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.”²⁷³ Thus, the PPACA has effectively extended the reach of the small employer exemption and further reduced the impact of the MHPAEA by doubling the size of the original definition of a small employer.

4. LIMITATIONS OF THE PPACA

The PPACA is a significant step in increasing access to mental health care for millions of Americans. However, much like prior federal parity efforts, the PPACA leaves several options open for insurers and employers to avoid implementation. The PPACA mandates that qualified health plans, certain Medicaid benchmark and benchmark-equivalent plans and plans offered through the individual market must provide essential health benefits. However, this mandate does

²⁶⁸ 42 U.S.C. § 300gg-26(B)(3)(B)(iii) (2010).

²⁶⁹ *Id.* § 300gg-26(B)(3)(B)(i).

²⁷⁰ Stone, *supra* note 258, at 17.

²⁷¹ PPACA § 1201.

²⁷² PPACA § 1304(b); see also DEP’T OF LABOR, FAQ’S ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART V AND MENTAL HEALTH PARITY IMPLEMENTATION (stating that small employers remain exempt from MHPAEA even after the passage of the PPACA), available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

²⁷³ PPACA § 1304(b).

not achieve full parity and is greatly weakened by changes to the small employer exception.

Specifically, the PPACA does include mental health and substance abuse disorders in the essential health benefits package, but the scope of services that must be provided has not been specified.²⁷⁴ In terms of mental health coverage, the essential health benefits package only provides coverage for “mental health and substance use disorder services, including behavioral health treatment.”²⁷⁵ The PPACA does not mandate specific service or treatment; rather it only requires that coverage is provided in all ten broad categories. Many questions remain unanswered, such as if the essential health benefits package includes vital mental health services like preventive services or even case management.

The PPACA has also hindered the achievement of mental health parity by expanding the small employer exemption to federal parity laws. By changing the definition of a small employer from fifty to one hundred employees, the mandate for essential health benefits is greatly weakened. Further, the PPACA continues many of the shortcomings of MHPAEA. For instance, the MHPAEA did not set a federal definition of mental illness, and in doing so avoided potential conflict with interest groups by allowing the insurer to define mental illness.²⁷⁶ Likewise, the PPACA does not set a federal definition of mental illness. Although the PPACA has taken some steps to provide health care coverage to Americans suffering from mental illness and substance abuse disorders, it is clear that the PPACA has yet to achieve full parity.

VII. POLICY PROPOSAL: A MENTAL HEALTH PARITY ACT WITH TEETH

Since federal legislation has yet to provide full mental health parity and end discriminatory practices targeted at mental health consumers, and because some states have yet to enact any form of parity legislation to protect mental health consumers,²⁷⁷ additional federal legislation must be advanced.

Mental health parity legislation should be drafted with four underlying goals in mind. Parity should be implemented to: 1) counteract the scientifically tenuous and discriminatory distinction between mental illness and physical illness, 2) eliminate adverse selection through mandatory parity, 3) reduce out-of-pocket expenses for mental health consumers, and 4) to stimulate the economy by increasing the productivity and societal contributions of the people seeking mental health care.²⁷⁸

²⁷⁴ Stone, *supra* note 258, at 17.

²⁷⁵ PPACA §1302(b)(1)(E).

²⁷⁶ 29 U.S.C. § 1185a(e)(4).

²⁷⁷ See CRS HISTORY, *supra* note 168, at 15.

²⁷⁸ See DHHS 1997, *supra* note 11, at 13.

Comprehensive mental health parity legislation should include four essential elements: 1) type of mandate, 2) terms and conditions, 3) definition of mental illness and 4) exemptions.²⁷⁹ First, considering the limitations of the mandated offering and mandated-if-offered statutes, anything short of mandated benefit legislation is unacceptable. As a foundation for parity policy this cannot be open to negotiation. Secondly, MHPAEA has already taken a significant step by requiring coverage terms and conditions to be in parity under a mandated-if-offered policy.²⁸⁰ A policy favoring equality among coverage terms and conditions must be retained in any subsequent federal mental health parity legislation. With these two premises in mind, the next step in advancing mental health parity is to set a mental illness definition and any exemptions.

A. SERIOUS MENTAL ILLNESS OR DSM-IV?

A definition of mental illness must be set before Congress can adequately address the needs of mental health consumers. Setting a concrete definition for mental illness has been debated across academic disciplines.²⁸¹ Defining what constitutes a mental illness is not as simple as defining general illnesses, since most mental illnesses do not have a biological marker.²⁸² Although mental illnesses often affect the brain and are associated with brain chemistry, the root of mental illness is largely unknown.²⁸³

Before legislatures can adopt a definition of mental illness, a proper perspective for understanding and treating mental health must first be considered. One model for understanding mental health is the biomedical model.²⁸⁴ This model assumes that all illness or disease can “be fully accounted for by deviations from the norm of measurable biological (somatic) variables.”²⁸⁵ Further “[t]he biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes.”²⁸⁶ However, this model is very limiting in that it overlooks the impact that social and psychological factors have on mental health. For instance, under a biomedical model it would not be possible to

²⁷⁹ Kaplan, *supra* note 1, at 351 (proposing another element in consideration of coverage for substance abuse).

²⁸⁰ 29 U.S.C. § 1185a(a)(3)(A).

²⁸¹ FRANK & GLIED, *supra* note 6, at 9.

²⁸² *Id.* See also KELLY, *supra* note 45, at 9 (stating that unlike communicable diseases, mental illness has “no pathogen—no viral infection—that can be readily identified and treated”).

²⁸³ KELLY, *supra* note 45, at 9-10.

²⁸⁴ George L. Engel, *The Need for a New Medical Model: A Challenge for Biomedicine*, 196 SCIENCE 129 (1977).

²⁸⁵ *Id.*

²⁸⁶ *Id.*

explain why some patients experience depression symptoms as “mental illness,” while other patients regard the same symptoms as merely “problems of living.”²⁸⁷

However, mental illness can be more comprehensively understood from a “biopsychosocial” perspective, which in turn will allow for a broader definition of mental illness.²⁸⁸ According to the biopsychosocial model, biological, psychological, and social factors all have a significant role in human functioning in the context of disease or illness.²⁸⁹ The biological component attempts to understand the cause of the mental illness in terms of the functioning of the body. For instance, some people may be genetically predisposed to mental illness and more vulnerable than the average person.²⁹⁰ The psychological component attempts to understand how psychological problems may cause mental illness. For instance, there may be associations between certain patterns of thinking and mental illness.²⁹¹ Specifically, a person prone to negative self-conclusions is more likely to become depressed.²⁹² Finally, the social component attempts to understand how social factors like culture, socioeconomic status, and religion may impact mental health. For instance, mental illness may be triggered by a person’s traumatic and stressful life experiences.²⁹³

Under the biopsychosocial model physicians evaluate how all three factors may contribute to the illness and patienthood, instead of merely considering biological factors alone.²⁹⁴ Thus, a valid definition for mental illness should account for each component of the biopsychosocial model in order to reach a broader section of mental health consumers.

One definition advanced by the Surgeon General defines mental illness as a term “refer[ing] collectively to all *diagnosable* mental disorders . . . [which] are characterized by abnormalities in cognition, emotion or mood, or the highest integrated aspects of behavior, such as social interactions or planning of future activities.”²⁹⁵ As Kelly adeptly points out, the operative word in the Surgeon General’s definition is *diagnosable*, which serves to separate mental illness from less serious life difficulties.²⁹⁶ *Diagnosable* means that the patient’s symptoms meet the designated observable or reportable level for a recognized mental illness in the current version of the *Diagnostic and Statistical Manual of*

²⁸⁷ See *id.*

²⁸⁸ KELLY, *supra* note 45, at 10.

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ *Id.*

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ Engel, *supra* note 284.

²⁹⁵ SURGEON GENERAL 1999, *supra* note 9, at 39 (emphasis added).

²⁹⁶ See KELLY, *supra* note 45, at 10 (quoting the Surgeon General defining mental illness as “diagnosable mental disorders”).

*Mental Disorders.*²⁹⁷

The current version of the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-IV-TR, was published by the American Psychiatric Association to provide

diagnostic criteria for each mental disorder . . . as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. . . . [The] diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in [the] field.²⁹⁸

Typically, insurers require a diagnosis in accordance with DSM-IV criteria for eligibility for mental health treatment.²⁹⁹ A definition of mental illness based on the DSM-IV has been advocated by scholars³⁰⁰ and adopted by twenty-nine states in mental health parity legislation as of 2007.³⁰¹ However, opponents of mental health parity are hostile to a definition of mental illness based on DSM-IV.³⁰² Parity opponents criticize Parity as defined by DSM-IV for allowing doctors to subjectively decide if a patient's condition qualifies as a disorder.³⁰³ Opposition also criticizes the DSM-IV for including disorders which they find undeserving of parity, including developmental-arithmetic disorder, oppositional-defiant disorder, caffeine intoxication and sleep disorders resulting from jet lag.³⁰⁴

Even parity proponents are divided as to if all 297 mental health disorders listed in DSM-IV should be treated equally.³⁰⁵ DSM-IV attempts to include "every possible category of mental illness regardless of severity . . . [and] includes forms of mental illness that do not warrant the same level of attention as, say, schizophrenia or major depression."³⁰⁶

²⁹⁷ See *id.* (describing how the DSM-IV is used to diagnose mental illness).

²⁹⁸ See AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* DSM-IV, xxvii (4th ed. 1994) (describing the diagnostic criteria used in the mental health field).

²⁹⁹ See KELLY, *supra* note 45, at 110 (describing the importance of DSM-IV criteria in diagnosing mental illness and its general acceptance in the mental health field).

³⁰⁰ See, e.g., Kaplan, *supra* note 1, at 360 (stating that "[a]t a minimum, [effective] legislation should incorporate the definition of mental illness from the most recent edition of the DSM-IV"); see also Barrett, *supra* note 28, at 1194 (advocating that Wisconsin should adopt mental health parity legislation based on DSM-IV).

³⁰¹ CRS HISTORY, *supra* note 168, at 15.

³⁰² Goodman and Mitchell, *supra* note 246, at 1 (stating that "[o]ne problem [with the DSM] is that there is no objective biological test to identify a mental disorder—not even schizophrenia).

³⁰³ *Id.*

³⁰⁴ See, e.g., *id.* and Schmall, *supra* note 66, at 665 (discussing other controversial disorders listed in the DSM-IV including sleep disorders resulting from jet lag, eating disorders, attention deficits and antisocial psychoses).

³⁰⁵ KELLY, *supra* note 45, at 11-12.

³⁰⁶ *Id.* at 12.

As a compromise, the concept of serious mental illness (“SMI”) has been adopted in eleven state parity statutes.³⁰⁷ Although a consensus definition has not emerged, the Surgeon General has stated that SMI “generally applies to mental disorders that interfere with some area of social functioning . . . [and] includes schizophrenia, bipolar disorder, and other severe forms of depression, panic disorder, and obsessive compulsive disorder.”³⁰⁸

The Surgeon General’s SMI definition includes psychotic mood and anxiety disorders, which respectively are the most severe and the most common mental illnesses.³⁰⁹ However, this definition excludes: personality disorders; child disorders such as attention deficit disorder, and hyperactivity disorder; eating disorders and substance abuse disorders, which are also common, debilitating and disabling.³¹⁰ Thus, a definition for SMI should include the disorders included by the Surgeon General but must also include psychotic disorder, mood disorder, anxiety disorders, personality disorders, childhood disorders, eating disorders and substance abuse disorders.³¹¹ Only by mandating parity according to this definition can policy makers ensure that those most in need of care are protected.³¹²

Further, the proposed SMI definition of mental illness for policy purposes will enable Congress to draft a bill that will face less opposition by not covering politically sensitive and controversial DMS-IV diagnoses, such as jet lag and caffeine intoxication. Moreover, the proposed SMI definition will not service an overbroad population. For example, in 2006, it was estimated that 6% or 13.2 million adults in the U.S. suffer from SMI.³¹³ While in 2005, it was estimated that 26.2% or 57.7 million adults in the U.S. had a mental illness as defined by the DSM-IV, which includes individuals with little or no daily life disruption.³¹⁴ Since the proposed SMI definition is congruent with the biopsychosocial model, while simultaneously prioritizing care and resources to people with the most serious need, the proposed SMI definition should be adopted in future legislation.

³⁰⁷ CRS HISTORY, *supra* note 168, at 15.

³⁰⁸ SURGEON GENERAL 1999, *supra* note 9, at 46.

³⁰⁹ KELLY, *supra* note 45, at 12-13.

³¹⁰ *Id.* at 13.

³¹¹ *Id.* at 96-97. In regards to personality disorders, many mental health professionals believe that personality disorders are the result of a patient’s childhood and adolescent experiences. “However, some data from family, twin, and adoption studies has suggested that biology does play a part in these disorders.” Utah Psych, *Personality Disorder* (2010), available at <http://www.utahpsych.org/personality.htm>. Further, studies have found a genetic link for both antisocial and borderline personality disorders. Thus, personality disorders are accounted for by the biopsychosocial and should be protected by mental health parity legislation. *Id.*

³¹² KELLY, *supra* note 45, at 97.

³¹³ *Id.* at 13. See also SURGEON GENERAL 1999, *supra* note 9, at 46 (noting that, in 1999, the Surgeon General reported that 5.4% of adults suffer from SMI).

³¹⁴ KELLY, *supra* note 45, at 96.

B. APPLICABLE EXEMPTIONS, POLITICAL REALITY AND COMPROMISE

Federal parity legislation and state parity legislation have included compliance exemptions for small businesses and a cost increase exemption for employers.³¹⁵ A perfect political climate would allow for exemption-free legislation similar to California or Vermont. However, exemptions have been provided as compromises to reduce opposition from interest groups and thus ensure that the legislation is adopted.³¹⁶

Seventeen states include a small business exemption to their mental health parity legislation.³¹⁷ These exemptions apply to employers with less than a designated number of employees, ranging from 10 to 51.³¹⁸ Parity opponents routinely cite a fear of a rise in healthcare costs as a result of parity.³¹⁹ Providing a small business exemption will help prevent further opposition. A small business exemption was included in MHPA and the MHPAEA and remains a political necessity to successfully enact further mental health parity legislation.

Fourteen states include a cost-increase exemption to their mental health parity legislation.³²⁰ These exemptions generally provide that “if a health plan demonstrates that providing parity mental health coverage raises the premium cost by more than a given %, they may be exempt from the mental health parity requirements.” However, as demonstrated with the examination of California’s and Utah’s parity legislation, large employers should not expect a cost increase over one percent and may even realize a reduction in overall cost. Even if a modest cost-increase exemption is provided in future legislation, it is unlikely that large employers will experience a cost-increase necessary to qualify for an exemption. Accordingly, a modest one to two percent cost-increase exemption should be included in future parity legislation. This cost-increase exemption ultimately will not bar mental health consumers from treatment, while its exclusion will increase opposition among businesses and interest groups. Thus, to gain maximum support for parity legislation, a small business and a modest cost-increase exemption should be included.

CONCLUSION: WHERE DO WE GO FROM HERE?

The enactment of the MHPAEA and the PPACA were a significant

³¹⁵ Vermont Parity, *supra* note 122, at 3.

³¹⁶ Mari C. Kjorstad, *The Current and Future State of Mental Health Insurance Parity Legislation*, 27 *PSYCHIATRIC REHABILITATION* J. 34, 37-38 (2003).

³¹⁷ CRS HISTORY, *supra* note 168, at 15-16.

³¹⁸ *Id.* at 16.

³¹⁹ See, e.g., Goodman and Mitchell, *supra* note 246 (stating that the U.S. spends the largest percentage of national income in the world on healthcare and generally expressing concerns about additional costs imposed by parity).

³²⁰ CRS HISTORY, *supra* note 168, at 15-16.

step in the right direction towards parity, but to achieve full parity Congress must pass mandated benefit legislation. However, society's discriminatory view and the stigma placed on mental healthcare must be challenged before parity is truly achieved. Although parity legislation in some states has increased access to care and the quality of life for mental health consumers, other states have adopted inadequate policies or nothing at all. Therefore, federal legislation is the only avenue available to ensure parity for all Americans. Accordingly, the policy recommendations in this article should be adopted as the next step towards full parity for mental health consumers.

APPENDIX I

