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## Legislative and Judicial Solutions for Mental Health Parity: S. 543, Reasonable Accommodation, and an Individualized Remedy Under Title I of the ADA

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Legislative and Judicial Solutions for Mental Health Parity: S. 543,  
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of the ADA

**Keywords**

Mental health, Americans with Disabilities Act (“ADA”), The Mental Health Equitable Treatment Act of 2001

## COMMENTS

# LEGISLATIVE AND JUDICIAL SOLUTIONS FOR MENTAL HEALTH PARITY: S. 543, REASONABLE ACCOMMODATION, AND AN INDIVIDUALIZED REMEDY UNDER TITLE I OF THE ADA

KEITH NELSON\*

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### INTRODUCTION

In January, 1997, the anguished mother of a depressed and bulimic sixteen year-old girl, who had unsuccessfully attempted suicide, placed a call to the director of the Vermont Mental Health Association.<sup>1</sup> Although both parents worked, and had purchased the best coverage available to them through their employer-sponsored Vermont Blue Cross/Blue Shield health benefits plan, the young girl had already reached the \$10,000 lifetime cap placed on mental health benefits under the plan.<sup>2</sup> Despite having spent thousands of dollars out-of-pocket for additional care, the girl still needed more medical treatment. Like hundreds of other families in Vermont, the girl's family faced a stark reality: doing everything to help their daughter might ruin them financially.<sup>3</sup>

Most Americans with private health care coverage receive coverage through their employer,<sup>4</sup> and most employer-sponsored plans offer the beneficiaries some basic level of mental health care coverage.<sup>5</sup>

1. See *Mental Health Parity Legislation: Hearings of the Comm. on Health, Educ., Labor, and Pensions*, 106th Cong. 83-84 (2000) (testimony of Ken Libertoff, Executive Director of the Vermont Association of Mental Health) [hereinafter Libertoff Testimony] (providing anecdotes from his experience in Vermont, where a state mental health parity bill was passed in 1997), available at <http://labor.senate.gov/Hearing/may00hr/051800wt/05180jnj/05190emk/domenici/rosen/wooldridge/allen/libertoff/libertoff.htm> (last visited Sept. 15, 2001).

2. See *id.* at 83 (explaining that although the medical plan provided \$1 million in lifetime benefits for "physical" illnesses, the plan severely restricted the amount of money available for mental health benefits, including annual financial limits and higher co-pays and deductibles).

3. See *id.* (reciting his experience fielding hundred of phone calls and visits from people coping not only with seriously ill family members but also confronted with the reality that they stood on the "brink of financial catastrophe").

4. See Thomas G. McGuire, *Predicting the Costs of Mental Health Benefits*, 72 MILBANK Q. 3, 4 (1994) (stating that of the sixty percent of Americans with private health insurance, employers constitute the largest source of private health care coverage).

5. See PAUL FRONSTIN ET AL., EBRI DATABOOK ON EMPLOYEE BENEFITS (Deborah

Most of those plans, however, severely restrict the amount of coverage provided for mental health services.<sup>6</sup> Those plans typically limit the number of inpatient hospital days and outpatient doctor visits<sup>7</sup> and impose higher cost sharing requirements on beneficiaries utilizing mental health services than on beneficiaries requiring treatment for physical illnesses.<sup>8</sup> For many individuals suffering from less severe mental illnesses, such as moderate depression or anxiety disorders, these benefit structures are not overly burdensome, as a proper medication regime coupled with limited inpatient hospitalization and outpatient therapy can effectively control certain mental illnesses.<sup>9</sup> For individuals with a more severe mental illness, however, such limitations on coverage can prove disastrous.<sup>10</sup> Beneficiaries who exhaust their coverage often are left without meaningful recourse,<sup>11</sup>

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Holmes et al., 4th ed. 1997) (noting that some level of mental health coverage is provided to over ninety percent of employees participating in employer-sponsored health plans).

6. See Sharon Bee & Mary Jo Gibson, *Mental Health Parity: An Overview of Recent Legislation*, AARP Public Policy Institute Research Summary, 1 (1998), at [http://research.aarp.org/health/fs69\\_mental.html](http://research.aarp.org/health/fs69_mental.html) (last visited Sept. 15, 2001) (explaining that while indemnity plans typically provided \$1 million in overall health care coverage, the media lifetime limit for mental health care coverage is only \$40,000).

7. See *id.* at n.3 (citing the 1998 study by the Hay Group to assert that forty-eight percent of all health plans limited the number of outpatient visits, and eighty-six percent limited inpatient hospital care).

8. See *id.* (relying upon the Hay Group's analysis to conclude that forty percent of all health plans, including indemnity and managed care plans, imposed annual dollar limits on outpatient psychiatric care).

9. See *American Medical Association Council on Long Range Planning and Development, The Future of Psychiatry*, 264 JAMA 2542, 2543 (1990) [hereinafter JAMA Report] (discussing how the advent of numerous new medications, such as Prozac and other anti-depressants, as well as other therapies, have made treatment more effective). See also Harold Alan Pincus et al., *Prescribing Trends in Psychotropic Medications: Primary Care, Psychiatry, and Other Medical Specialties*, 279 JAMA 526, 531 (1998) (discussing the emergence and wide-ranging prescription of new drugs helping treat a variety of ailments such as anxiety and depression without the negative side effects of older medications).

10. See 141 CONG. REC. 3001 (1995) (statement of Sen. Domenici) [hereinafter Domenici Statement] (charging that failure to provide equal and adequate treatment to the mentally ill results in an escalation of symptoms, pushing the mentally ill to the "margins of society"); cf. *H.R. 217-Homeless Housing Programs Consolidation and Flexibility Act: Hearings Before the Subcomm. on Hous. and Cmty. Opportunity of the Comm. on Banking and Fin. Servs.*, 105th Cong. 44 (1997) (testimony of Dr. E. Fuller Torrey, M.D., Research Psychiatrist, Neuroscience Center, National Institute of Mental Health) [hereinafter Fuller Testimony] (stating that "[t]he second largest cause of homelessness is severe psychiatric illness, specifically schizophrenia and manic-depressive illness (bipolar disorder) . . . [and] studies consistently have found that between 25 and 45 percent of homeless individuals have a severe psychiatric disorder, not including those with a primary diagnosis of substance abuse."), available at <http://www.house.gov/banking/3597torr.htm> (last visited Sept. 15, 2001).

11. See Employee Retirement Income Security Act ("ERISA") § 502(a), 29 U.S.C. § 1132(a)(1)(B) (1994) (limiting ERISA plan beneficiaries' legal recourse to "actions

and their mental illnesses progress unchecked, disrupting their lives in fundamental ways.<sup>12</sup>

Mental health advocates and consumers have long decried this situation, seeking on numerous fronts to eliminate unequal treatment between mental and physical illness.<sup>13</sup> Due in part to their efforts, legislation prohibiting disparate treatment of mental illness has been considered in nearly every state legislature in the United States,<sup>14</sup> and similar bills have been introduced in both Houses of Congress in recent years.<sup>15</sup> Mental health consumers and advocates also have sought relief in numerous federal courts throughout the country,<sup>16</sup> seeking a judicial declaration that unequal benefits are discriminatory and illegal.<sup>17</sup>

The results of those efforts, however, fall far short of systemic, comprehensive reform.<sup>18</sup> Although a solid majority of states have passed some form of protection for the mentally ill,<sup>19</sup> this protection

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to recover benefits due under the plan; actions to enforce benefits due under the plan; or clarification of rights to future benefits.”).

12. See *supra* note 10 and accompanying parentheticals (detailing the results of untreated mental illness).

13. See discussion *infra* Parts I.B-C, III (discussing parity proponents’ efforts in state legislatures, Congress, and federal courts).

14. See discussion *infra* Part I.B (detailing the parity measures considered and passed by state legislatures); see also Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 14 n.61 (2000) (discussing state parity laws and providing overview of pending state and federal legislative efforts, in addition to surveying recent court cases that seek parity for mental health benefits). See generally United States General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, GAO/HEHS-00-95 (2000) [hereinafter GAO Letter Report] (reporting on compliance with Mental Health Parity Act of 1996 and providing thorough examination of state parity law), available at [http://www.access.gpo.gov/su\\_docs/aces/aces160.shtml](http://www.access.gpo.gov/su_docs/aces/aces160.shtml) (last visited Sept. 15, 2001).

15. See The Equitable Health Care for Severe Mental Illness Act of 1995, S. 298, 104th Cong. § 4 (1995) (mandating nondiscriminatory and equitable health care coverage for persons with severe mental illness); see also Mental Health and Substance Abuse Parity Amendments of 1998, H.R. 3568, 105th Cong. § 2 (1998) (prohibiting imposition of “treatment limitations or financial requirements” on mental health care benefits if similar restrictions also have not been applied to “coverage of medical and surgical benefits in comparable settings (including inpatient and outpatient settings).”); Mental Health Equitable Treatment Act of 1999, S. 796, 106th Cong. § 2 (1999) (prohibiting lesser coverage for inpatient hospital days and outpatient doctor visits, and providing full parity in benefits for individuals suffering from “severe mental illness,” i.e. those that are “biologically based.”).

16. See *infra* text accompanying note 169 (observing that mental parity benefit cases have been argued in front of the Second, Third, Fourth, Sixth, Seventh, Ninth, Tenth and the District of Columbia Circuits).

17. See discussion *infra* Part III (discussing court challenges to unequal treatment brought under the Americans with Disabilities Act).

18. See discussion *infra* Part I.B-C (concerning the limitations of both state and federal parity measures).

19. See GAO Letter Report, *supra* note 14, at 8 (stating that twenty-nine states

is limited in several important ways.<sup>20</sup> Similarly, although Congress passed mental health parity legislation in 1996,<sup>21</sup> its scope and reach also are strictly circumscribed.<sup>22</sup> Further, legal challenges to unequal treatment have been largely futile, with numerous federal courts across the country unanimously holding that lesser coverage for mental illnesses in health and disability benefits is neither discriminatory nor illegal.<sup>23</sup> Accordingly, the most important and enduring goal of mental health advocates and consumers remains unfulfilled: that equal access to services and benefits would allow people suffering from mental illness to lead “normal” productive lives in society like any other citizen.<sup>24</sup>

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have parity laws more comprehensive than that required by the Mental Health Parity Act of 1996). Sixteen of these states require full parity in all benefit categories and in all plans sold. *See id.* While six states parallel the 1996 Mental Health Parity Act (“MHPA”), eight states and the District of Columbia have laws requiring more limited benefits, and the laws of seven states fail to address mental health benefits. *See id.*

20. *See* discussion *infra* Part I.B (discussing the limitations of state-passed parity measures, especially in relation to ERISA preemption of state regulation).

21. *See* Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 712, 110 Stat. 2944, 2945-47 (codified at 29 U.S.C. § 1185a (1994 and Supp. IV 1998)) [hereinafter 1996 MHPA] (providing parity for annual and lifetime aggregate spending caps between mental and physical illness).

22. *See id.*

23. *See* EEOC v. Staten Island Sav. Bank, 207 F.3d 144, 149-50 (2d Cir. 2000) (refusing to extend ADA protections to unequal long-term disability benefits for mental and physical disabilities because different treatment is “a nearly universal practice inherent in the insurance industry”, and, had Congress intended to reach this disparity with the ADA, it was have explicitly stated so); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1108 (9th Cir. 2000) (unsuccessfully challenging lesser benefits provided for disability attributable to severe depression than those provided for physical disabilities); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1102 (10th Cir. 1999) (holding that the ADA does not bar employers from utilizing long-term disability benefit plans that differentiate between physical and mental disabilities in the provision of care); *Lewis v. Kmart Corp.*, 180 F.3d 166, 172 (4th Cir. 1999) (overruling a district court decision that held lower long-term disability coverage for severe depression constituted a violation of the ADA); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998) (declaring that disparity between mental and physical disability benefits does not violate ADA and dismissing plaintiff’s discrimination claim); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1015 (6th Cir. 1997) (denying relief in a claim virtually indistinguishable from *Weyer* and explaining that ADA only prohibits discrimination between the disabled and non-disabled rather than between the mentally and physically ill); *EEOC v. CNA Ins. Co.*, 96 F.3d 1039, 1045 (7th Cir. 1996) (barring a disabled employee’s ADA claim stemming from lesser coverage for severe depression and bi-polar disorder in long-term disability benefits); *Moddero v. King*, 82 F.3d 1059, 1064-65 (D.C. Cir. 1996) (rejecting the claim that a \$75,000 lifetime cap on mental health benefits violated the Rehabilitation Act).

24. *See* Domenici Statement, *supra* note 10, at 3002 (arguing that individuals suffering from mental illness could, given adequate medical treatment and behavioral therapy, “lead a life as normal as yours or mine.”); *see also* 142 CONG. REC. S9292 (daily ed. July 31, 1996) (statements of Sen. Domenici after the Conference Committee rejected the original Senate parity amendment) (urging Senate Committee on Labor, Health and Human Services to reconsider mental health parity

Despite these legislative and judicial impediments, opportunities still exist in both Congress and the federal courts for those seeking equal treatment between mental and physical illness. This Comment addresses these opportunities, promoting a dual-track strategy for attaining equal treatment in health care benefits for the mentally ill. Specifically, this Comment recommends that mental health parity legislation currently being considered by Congress, S. 543,<sup>25</sup> should be adopted to achieve parity in a manner designed to expand access to more comprehensive services while simultaneously controlling and/or reducing the associated costs.<sup>26</sup> Second, this Comment proposes a strategy for expanding legal, employment-based protections for individuals with mental illnesses under the Americans with Disabilities Act (“ADA”). Although the federal courts have demurred from making a blanket declaration that unequal benefits are illegal under the ADA,<sup>27</sup> by focusing on a “reasonable accommodation” analysis under Title I of the ADA, a viable rationale for a case-specific solution emerges.<sup>28</sup>

Part I of this Comment briefly examines the background and sociological aspects of unequal medical coverage for mental illness, and discusses the legislative history of parity in state legislatures and Congress. Part II surveys current parity legislation and asserts that it

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legislation because “parity . . . will say to the 5 million severely mentally ill Americans and their families that they are not going to be treated any longer like second-rate, if not third rate, citizens.”)

25. See The Mental Health Equitable Treatment Act of 2001, S. 543, 107th Cong. (2001) (amending the Employee Retirement Income Security Act of 1974 by prohibiting “any treatment limitations or financial requirements with respect to the coverage of benefits for mental illnesses unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits”), *available at* [http://www.access.gpo.gov/su\\_docs/aces/aces160.shtml](http://www.access.gpo.gov/su_docs/aces/aces160.shtml) (last visited Sept. 15, 2001). S. 543 was introduced on March 15, 2001, and referred to the Senate Health, Education, Labor and Pensions (“HELP”) Committee. See 147 CONG. REC. S2395-95 (daily ed. Mar. 15, 2001). On July 11, 2001, the HELP Committee conducted hearings, the marked-up version was reported to the Senate on September 6, 2001. See 147 CONG. REC. S9197 (daily ed. Sept. 6, 2001). On October 30, 2001, Senators Domenici and Wellstone offered S. 543 as an amendment to the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act (“Labor-HHS Approps”), where it was accepted on a voice vote. See 147 CONG. REC. S11165-85, S11216-17 (daily ed. Oct. 30, 2001). On November 6, 2001, the Senate passed their version of Labor-HHS Approps, containing S. 543’s provisions. See H.R. 3061 (as engrossed in Senate), Title VII—Mental Health Equity, S11458-75 (daily ed. Nov. 6, 2001). The House version of Labor-HHS Approps contains no such provision, so the fate of S. 543 remains largely in the hands of the Labor-HHS Conference Appointees.

26. See *id.*

27. See discussion *infra* Part III (surveying federal appellate court decisions denying relief in cases challenging unequal benefits between mental and physical illness).

28. See discussion *infra* Part IV.C (covering the notion of “reasonable accommodation” and related ADA precedent).



is a properly structured and necessary measure in the battle for full and equal coverage. Part III examines the important legal challenges to unequal coverage for mental illness and summarizes the courts' decisions. Finally, Part IV suggests an alternative, individualized strategy for bringing unequal coverage under the purview of Title I of the ADA through the ADA's "reasonable accommodation" provisions. Part IV also enumerates the possible tests and impediments such a strategy would encounter, and applies the "reasonable accommodation" analysis to a potential real-world scenario.

The legislative and judicial approaches are independent but complimentary. Although neither approach represents a panacea for the problem of unequal coverage, both approaches seek to advance legal protections for the mentally ill.<sup>29</sup> These approaches serve to buttress the arguments that: (1) those suffering from mental illness can receive effective medical treatment;<sup>30</sup> (2) given the proper treatment, individuals living with a mental illness can lead "normal," productive lives;<sup>31</sup> and (3) providing effective and adequate mental health care treatment would not be prohibitively expensive.<sup>32</sup>

## I. Background

### A. *Scientific Progress Versus Social Preconception*

Historically, individuals with a mental illness have been treated with contempt, fear, and cruelty.<sup>33</sup> Lacking a medical explanation for an individual's strange behavior, societies often concluded that mental illness stemmed from parental misdeeds, demonic possession, or simply deficient character.<sup>34</sup> Even well into the 20th Century, the

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29. See discussion *infra* Parts II and IV (discussing how legislation and targeted litigation would advance the goal of equal treatment for Americans with a mental illness).

30. See Domenici Statement, *supra* note 10, at 3002-03 (describing treatment success rates for mental illness). Treatment for bipolar disorder has an eighty percent success rate; schizophrenia, a sixty percent success rate; and major depression, a sixty-five percent success rate. See *id.* at 3002.

31. See *id.* at 3002 (stating that proper medical treatment can enable an individual, who suffers from mental illness, to lead a "normal" life).

32. See discussion *infra* Parts I.D and II.A (covering opposition cost arguments and citing studies demonstrating that mental health parity measures do not lead to "runaway" health insurance costs).

33. See Domenici Statement, *supra* note 10, at 3001 (providing examples of the often brutal measures taken against the mentally ill in the past).

34. See *id.* See generally Alison Bass, *Stigma Against Mental Illness Persists Despite New Research*, HOUS. CHRON., Feb. 16, 1992, at 3 (referring to the tendency in Western culture to ostracize and abandon individuals with a mental illnesses because "Anglo-American culture places such a high premium on individual autonomy and willpower [sic] that... people have trouble understanding why someone with

mentally ill were institutionalized, imprisoned, and/or forcibly sterilized.<sup>35</sup> In the last few decades, however, medical science has made dramatic breakthroughs in understanding, diagnosing, and treating mental illness.<sup>36</sup> Of pivotal importance is the recognition that many mental illnesses have both physiological and biological causes, blurring the historically sharp distinction between mental and physical illnesses.<sup>37</sup> Such discoveries consequently have helped to dispel much of the mystery and stigma surrounding mental illnesses.<sup>38</sup> Unfortunately, however, old habits die hard, and despite a relatively enlightened medical perspective on the causes of mental illness, society continues to harbor a deeply-held suspicion of both mental illnesses and the mentally ill.<sup>39</sup>

Nowhere is the gap between science and society more pronounced than in health benefit coverage for mental illness.<sup>40</sup> Despite medical evidence that mental illnesses are partly physical in origin,<sup>41</sup> insurers and group health plans still separate mental illness from other

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schizophrenia or profound depression cannot simply will himself to recover.”); STEPHEN M. STAHL, *ESSENTIAL PSYCHOPHARMACOLOGY: NEUROSCIENTIFIC BASIS AND CLINICAL APPLICATIONS* 100 (1998) (citing surveys showing that seventy-one percent of Americans believe mental illness stems from emotional weakness, sixty-five percent attribute it to bad parenting and forty-five percent think mental illness is the fault of the victim and that mental illness can be “willed away”).

35. See discussion *infra* Part I.A (discussing the relation of mental illness to homelessness and imprisonment); see also Domenici Statement, *supra* note 10, at 3001 (stating that as late as 1972 the mentally ill of some states were sterilized without their consent or knowledge).

36. See *Hearing Before the Subcomm. on Labor Health & Human Servs., Educ. & Related Agencies of the House Comm. on Appropriations*, 104th Cong. 371 (1996) (statement of Dr. Stephen E. Hyman, Director, Nat'l Inst. of Mental Health, Dep't of Health & Human Servs.) [hereinafter Hyman Testimony] (describing the progress of the medical community in stating that in previous years a severe mental illness spelled “a life sentence” whereas today, the medical profession is “crackling with new hope because new medications ha[ve] revolutionized [the] clinical practice” and the study of mental disorders).

37. See *id.* at 373 (voicing “widespread consensus that mental illnesses are just as real, as medically valid, as other brain disorders”); see also *id.* at 375 (further emphasizing the advancements of medical research into mental illnesses and explaining that “the accumulating weight of the evidence . . . demonstrates that mental disorders *are* brain diseases.”) (emphasis in original).

38. See Domenici Statement, *supra* note 10, at 3002 (lauding the increased level of public understanding of mental illness).

39. See STAHL, *supra* note 34, at 100 (listing common social misconceptions of mental illness).

40. See Bee & Gibson, *supra* note 6 (detailing common inequalities in health care coverage between physical and mental illnesses); see also Domenici Statement, *supra* note 10, at 3002 (noting that only two percent of Americans with private health insurance have health care coverage that provides mental health benefits equal to those provided for physical illnesses).

41. See Hyman Testimony, *supra* note 36, at 375-76 (discussing pertinent scientific, biological and genetic evidence linking mental illnesses to brain disorders by citing, *inter alia*, abnormal cerebral ventricles and under-developed nerve cells in brains of schizophrenics).

categories of illnesses, and provide the mentally ill less health insurance coverage and treatment.<sup>42</sup> Typically, this inequality manifests itself in lower overall financial limits for mental health benefits,<sup>43</sup> higher co-payments and deductibles,<sup>44</sup> and fewer covered inpatient hospital days and outpatient doctor visits.<sup>45</sup> The consequences of these inequalities include prematurely exhausted benefits,<sup>46</sup> and exacerbation of the underlying illness and symptoms,<sup>47</sup> often leading to homelessness<sup>48</sup> or imprisonment.<sup>49</sup>

Rather than waiting for insurers to close the gap by instituting parity on their own accord, mental health consumers and advocates have focused on correcting this disparity through the legal process.<sup>50</sup> Accordingly, advocates and consumers have turned to their elected

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42. See *supra* note 10 (discussing the different insurance treatment of mental illness).

43. See *supra* notes 6-8 and accompanying text (describing dramatic financial disparity between physical and mental health care coverage).

44. See *id.*

45. See *id.*

46. See *supra* notes 1-3 and accompanying text (providing example of a mentally ill teenager from Vermont who, by age 16, had already reached the lifetime cap on mental health benefits according to the insurance plan); see also David Satcher, M.D., Ph.D., U.S. Dep't of Health & Human Servs., *Mental Health: A Report of the Surgeon General*, Surgeon General's Preface (containing the statement of the Surgeon General referring generally to inadequate mental health benefits), available at <http://www.surgeongeneral.gov/library/mentalhealth/home.html> (last visited Nov. 5, 2001).

47. See Domenici Statement, *supra* note 10, at 3002 (criticizing denial of medical treatment to the mentally ill because "problems associated with nontreatment will continue to escalate," causing further marginalization of those suffering from mental illness).

48. Fuller Testimony, *supra* note 10, at 44 (estimating that in 1997 there were 150,000 homeless with severe psychiatric disabilities nationwide and predicting that figure will continue to climb).

49. See Fox Butterfield, *Prisons Replace Hospitals for the Nation's Mentally Ill*, N.Y. TIMES, Mar. 5, 1998, at A1 (analyzing "criminalization of the mentally ill" and reporting on a 1998 estimation by the U.S. Department of Justice, Bureau of Justice Statistics, that ten percent of all inmates in state and federal prisons, or approximately 200,000 prisoners, are severely mentally ill). Most of these mentally ill inmates commit minor infractions, such as disturbing the peace or vagrancy. Others commit no infraction, but are jailed on "mercy" arrests, where authorities feel they have no other option. See *id.* See also *The Mentally Ill in Jail*, National Association of Counties Fact Sheets (June 2001) (estimating that, of the ten million people entering county jails each year, nearly sixteen percent are suffering from mental illness), available at <http://www.naco.org/leg/facts/01mentallyill.cfm> (last visited Sept. 15, 2001). See generally *Mental Illness in U.S. Jails: Diverting the Nonviolent, Low-Level Offender*, Center on Crime, Communities, & Culture, Open Society Institute, Research Brief, No. 1, Nov. 1996 (asserting that the number of mentally ill individuals admitted into U.S. jails annually is nearly eight times the number of patients admitted into state mental hospitals), available at [http://www.soros.org/crime/research\\_brief\\_1.html](http://www.soros.org/crime/research_brief_1.html) (last visited Sept. 15, 2001). Of the jails surveyed, nearly one-third reported having admitted mentally ill individuals against whom no criminal charges had been filed. See *id.*

50. See discussion *infra* Parts I.B-C, II and III (covering legislative and court efforts to achieve mental health benefits parity).

representatives, seeking to legislatively prohibit unequal coverage.<sup>51</sup>

### B. State Legislatures

For over a decade, state legislatures across the country have considered mental health parity measures,<sup>52</sup> with a majority of states passing laws providing some protection for the mentally ill.<sup>53</sup> However, despite this apparently broad-ranging embrace of mental health coverage,<sup>54</sup> vast disparities in coverage requirements exist between states,<sup>55</sup> and only a minority of states require coverage for mental illness that can truly be described as equal to coverage of physical ailments.<sup>56</sup>

In those states requiring full parity,<sup>57</sup> the actual population to which these mandates apply is severely limited by the Employee Retirement Income Security Act ("ERISA") of 1974.<sup>58</sup> ERISA is a far-reaching federal regulatory regime<sup>59</sup> designed to create nation-wide

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51. See discussion *infra* Part I.B-C (analyzing state and federal legislative action toward mental health parity).

52. See GAO Letter Report, *supra* note 14, at 6 (stating that during the past decade, a majority of states have enacted mental health coverage legislation).

53. See *id.* at 8 (summarizing a National Conference of State Legislatures' (NCSL) Health Policy Tracking Service report that forty-three states and the District of Columbia have mental health coverage laws in place, though with differing coverage requirements). Twenty-nine states have parity laws more comprehensive than that required by the Mental Health Parity Act of 1996 (MHPA), with sixteen states requiring full parity in all benefit categories and in all plans sold; six states parallel the MHPA; and eight states and the District of Columbia have laws requiring more limited benefits. See *id.* Only Alabama, Idaho, Iowa, Michigan, Oregon, Utah and Wyoming are without a corresponding law. See *id.* California, the District of Columbia, Illinois, Massachusetts, Mississippi, North Dakota, Ohio, Washington and Wisconsin have more limited parity laws. See *id.* Alaska, Arizona, Florida, New Mexico, South Carolina, West Virginia, Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Indiana, Kansas, Kentucky, Louisiana, Maine, Minnesota and Missouri meet the requirements of Federal law. See *id.* Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont and Virginia exceed the requirements of Federal law.

54. See *id.* (noting that forty-three states and the District of Columbia have instituted mental health coverage laws).

55. See *id.* (recognizing that twenty-nine states have parity laws more comprehensive than that required by the Mental Health Parity Act of 1996 (MHPA), with sixteen states requiring full parity in all benefit categories and in all plans sold; six states parallel the MHPA; and eight states and the District of Columbia have laws requiring more limited benefits). See *id.*

56. See *supra* note 54 (listing the sixteen states requiring full parity in benefit categories and in all plans sold).

57. See *supra* note 54 (listing the states requiring full parity).

58. See ERISA, § 514(a), 29 U.S.C. § 1144(a) (1994) (stating that ERISA supersedes all state laws that relate to any employee benefit plan, thus preempting state-mandated laws).

59. See *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (stating that "[t]he pre-emption clause [of ERISA] is conspicuous for its breadth. It establishes as an area of exclusive federal concern the subject of every state law that 'relate[s]' to an employee

stability and uniformity in employee benefit plans.<sup>60</sup> ERISA specifically preempts state-mandated benefit laws by “supersed[ing] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>61</sup> As of 1998, almost forty percent of Americans under age sixty-five in private group health insurance plans, or approximately forty-eight million people, were in ERISA plans not subject to state-level regulation.<sup>62</sup>

Courts have held that ERISA preempts many state common law actions against covered health plans.<sup>63</sup> In *Tolton v. American Biodyne, Inc.*,<sup>64</sup> a suicide victim’s estate sued several doctors and the CIGNA Health Plan of Ohio (“CIGNA”) for wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith.<sup>65</sup> The Sixth Circuit, reasoning that “varying state causes of action . . . would pose an obstacle to the purposes and objectives of Congress,”<sup>66</sup>

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benefit plan governed by ERISA.”).

60. See N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656-57 (1995) (explaining that § 514 indicates Congress’ intent to regulate employee welfare benefits plans as a federal concern).

[ERISA] ensure[d] that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . [preventing] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

*Id.* at 656-57 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

61. ERISA, § 514(a), 29 U.S.C. § 1144(a) (1994). See also *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 941-42 (6th Cir. 1995) (stating that ERISA was intended to replace the “patchwork scheme of state regulation of employee benefit plans with a uniform set of federal regulations”).

62. See *Implications of ERISA for Health Benefits and the Number of Self-Funded ERISA Plans*, Employee Benefit Research Institute, Issue Brief (Jan., 1998) (noting that the U.S. General Accounting office found that forty-four million individuals were enrolled in self-funded ERISA plans in 1993 representing an increase of five million since 1989), available at <http://www.ebri.org/ibex/ib193.htm> (last visited Sept. 15, 2001). However, the ability of states to mandate certain levels of mental health coverage for insurance companies offering plans within state boundaries has been upheld. See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 725 (1985) (upholding a Massachusetts state law requiring “insurance plans” offering policies in the state to provide a minimum level of mental health benefits). In *Metropolitan Life*, the Supreme Court found that the Massachusetts mandate applied to “insured plans” (i.e. the Court was cognizant that the decision would result in a differentiation between insured and uninsured plans), and that the state law was therefore not preempted by ERISA, which allows traditional state regulation of insurance companies. See *id.* at 747.

63. See discussion *infra* Part I.B (explaining how ERISA preemption limits the reach of state parity laws).

64. 48 F.3d 937 (6th Cir. 1995).

65. See *Tolton*, 48 F.3d at 942 (“Plaintiff’s stated claims . . . all arise from [defendant’s] refusal to authorize psychiatric benefits . . .”).

66. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52 (1987). *Pilot* stated that “[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that

held that the plaintiff's state claims were preempted by ERISA.<sup>67</sup> The plain effect of ERISA preemption limits the beneficiary's remedies to those provided in ERISA § 502(a), specifically: (1) actions to recover benefits due under the plan;<sup>68</sup> (2) actions to enforce participant's rights under the plan;<sup>69</sup> or (3) actions to clarify the right to future benefits.<sup>70</sup> Subsequently, "one consequence of ERISA preemption . . . is that plan beneficiaries bringing certain types of actions—such as wrongful death—may be left without meaningful remedy."<sup>71</sup> Therefore, if the mentally ill are to acquire a "meaningful remedy" to health benefit inequality, federal law must lead the way.

### C. Congress

Due to the practical limitations of state-passed parity law,<sup>72</sup> the need for a federal parity law reaching self-insured ERISA health benefit plans has become acute. In the early 1990s, Congress began concerted efforts to pass a federal law eliminating inequalities in coverage for mental illness.<sup>73</sup> In 1992, Senators Pete V. Domenici (R-NM) and Paul Wellstone (D-Minn.) introduced S. 2696, "The Equitable Health Care for Severe Mental Illness Act of 1992."<sup>74</sup> The Act required employer-sponsored group health plans to provide coverage for "severe mental illness"<sup>75</sup> in a non-discriminatory manner.<sup>76</sup> Although this legislation garnered considerable

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Congress rejected in ERISA." *Id.* at 54.

67. See *Tolton*, 48 F.3d at 941-43.

68. See ERISA, § 502(a), 29 U.S.C. § 1132(a)(1)(B) (1994).

69. See *id.* (stating that, "[a] civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan . . .").

70. See *id.*

71. *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995).

72. See discussion *supra* Part I.B (discussing the ERISA's limitations).

73. See Equitable Health Care for Severe Mental Illness Act of 1992, 138 CONG. REC. S6490 (daily ed. May 12, 1992) (statement of Sen. Domenici) (stating that the bill should serve as a model mental health benefits plan and additionally should place Congress on notice to treat mental health issue with the same deference as traditional physical illnesses).

74. See *id.* (urging that mental health benefits should not be left "off the table" merely due to cost concerns).

75. See S. 2696, 102d Cong. § 3 (1992) (requiring that equal coverage be extended to "severe mental illness," but not defining what specific illnesses or diagnoses would qualify as "severe").

76. See *id.* § 4.

To be considered non-discriminatory and equitable under this Act, health coverage shall cover services that are essential to the effective treatment of severe mental illness in a manner that (1) is not more restrictive than coverage provided for other major physical illnesses; (2) provides adequate financial protection to the person requiring the medical treatment for a severe mental illness; and (3) is consistent with effective and common

attention,<sup>77</sup> and helped galvanize the mental health community,<sup>78</sup> the legislation ultimately died in the 102d Congress without further action.<sup>79</sup> The 1992 bill did, however, signal the first salvo in what has become an ongoing, annual legislative battle.<sup>80</sup>

In 1996, the combined efforts of dedicated legislators and advocates paid dividends when Congress passed the “Mental Health Parity Act of 1996” (“1996 MHPA”).<sup>81</sup> Although the federal law signified a breakthrough for advocates and consumers,<sup>82</sup> the 1996 MHPA actually offers only limited protection for the mentally ill.<sup>83</sup> The 1996 MHPA requires a group health plan offering a mental health benefit in conjunction with medical/surgical benefit to provide equality for any annual or lifetime aggregate spending caps imposed within the plan, i.e. the same amount of money must be equally available under both benefit categories for both mental and physical illness.<sup>84</sup> However, the 1996 MHPA fails to: (1) require

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methods of controlling health care costs for other major physical illnesses.

*Id.*

77. See Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63, 64 (1997) (stating that the 1996 MHPA “generated a substantial debate about the role of insurance with respect to mental health care, in general, as well as the treatment of serious mental illness, and the measure served to place the issue before the nation’s citizens.”).

78. See *id.* (referring to further anticipated advocacy for parity).

79. See S. 2696, 102d Cong. (1992).

80. See The Equitable Health Care for Severe Mental Illness Act of 1995, S. 298, 141 CONG. REC. 3001 (Jan. 31, 1995) (attempting to establish a “comprehensive policy [for] health care coverage and services to individuals with a severe mental illness and noting this bill had been introduced previously); see also Mental Health and Substance Abuse Parity Amendments of 1998, H.R. 3568, 105th Cong. (Mar. 26, 1998) (amending the 1996 MHPA); The Mental Health Equitable Treatment Act of 1999, S. 796, 106th Cong. (Apr. 14, 1999) (requiring parity for inpatient hospital days and outpatient doctor visits, and full parity for “severe mental illness”).

81. Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 702(a), 110 Stat. 2944 (Sept. 26, 1996).

82. See Robert Pear, *Conferees Agree on More Coverage for Health Care*, N.Y. TIMES, Sept. 20, 1996, at A1 (containing Senator Domenici’s description of the Act as “a historic step, a breakthrough, for the severely mentally ill . . . [Congress has taken] one step to get rid of the terrible stigma and discrimination that’s based on mystique, mystery and Dark Age concepts”); see also *Mental Health Parity Act to Take Effect at Midnight: Landmark Law to Benefit Millions of Americans*, Media Alert, National Alliance for the Mentally Ill (Dec. 31, 1997) (quoting Laurie Flynn, Executive Director of NAMI, as stating that “[t]he days of being cast as second-class citizens from a health care system historically indifferent to their needs are over.”), at <http://www.nami.org/pressroom/971231182629.html> (last visited Sept. 16, 2001).

83. See, e.g., 29 U.S.C. § 1185a(b)(1) (1994 & Supp. V 1999) (requiring actual equality in benefits only for lifetime and annual aggregate spending caps).

84. See 29 U.S.C. § 1185a(a) (1994 & Supp. V 1999).

(a) In general

(1) Aggregate lifetime limit. In the case of a group health plan . . . that provides both medical and surgical benefits and mental health benefits—

(A) No lifetime limit. If the plan or coverage does not include an aggregate

health insurers to actually offer a mental health benefit;<sup>85</sup> (2) prohibit group health plans from using other methods to control utilization or imposing higher copays and deductibles for mental health services;<sup>86</sup> (3) apply to small businesses employing from two to fifty employees;<sup>87</sup> or (4) extend to substance abuse treatments.<sup>88</sup> Furthermore, the bill contains a provision allowing insurers to opt-out of parity, despite meeting other requirements, if providing parity coverage raises overall plan costs more than one percent.<sup>89</sup> Lastly, the bill contains a “sunset” provision, phasing-out the parity requirements for benefits furnished on or after September 30, 2001.<sup>90</sup>

lifetime limit [on medical or surgical benefits, it] may not impose any aggregate lifetime limit on mental health benefits.

(B) Lifetime limit. If the plan or coverage includes an aggregate lifetime limit . . . the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits . . . and to mental health benefits and not distinguish in the application of such limit . . . or

(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

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(2) Annual Limits. In the case of a group health plan . . . that provides both medical and surgical benefits and mental health benefits—

(A) No annual limit. If the plan or coverage does not include an annual limit . . . [it] may not impose any annual limit on mental health benefits.

(B) Annual limit. If the plan or coverage includes an annual limit . . . the plan or coverage shall either—

(i) apply [such limit] to both the medical and surgical benefits . . . and to mental health benefits and not distinguish in the application of such limit . . . or

(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

*Id.*

85. *See id.* § 1185a(b)(1) (“Nothing in this section shall be construed . . . as requiring a group health plan . . . to provide any mental health benefits.”).

86. *See id.* § 1185a(b)(2). [This section shall not affect] the terms and conditions [of a group health plan offering a mental health benefits] (including cost sharing, limits on the number of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits . . . except as provided [in regard to parity in lifetime limits or annual limits.] *Id.*

87. *See id.* § 1185a(c)(1). (“This section shall not apply to any group health plan . . . for any plan year of a small employer.”) Small employer is defined as “an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.” *Id.*

*Id.* § 1185a(c)(1)(B).

88. *See id.* § 1185a(e)(4) (“The term ‘mental health benefits’ . . . does not include benefits with respect to treatment of substance abuse or chemical dependency.”).

89. *See id.* § 1185a(c)(2) (“This section shall not apply . . . if the application of this section results . . . in an increase in the cost under the plan (or for such coverage) of at least one percent.”).

90. *See id.* § 1185a(f) (“This section shall not apply to benefits for services furnished on or after September 30, 2001.”).



Consequently, the 1996 MHPA has been criticized by some observers as incomplete and inadequate.<sup>91</sup>

#### D. *Opposition to Parity*

The limitations included in the final 1996 MHPA, however, belie the vigorous effort exerted by the legislation's sponsors to increase protection for the mentally ill,<sup>92</sup> and instead should be primarily attributed to intense opposition lodged by several interest groups to any mental health parity requirement.<sup>93</sup> Congress, and many observers and interested parties, were taken by surprise by the passage of an initial, far-reaching parity bill in April of 1996, offered by Senators Domenici and Wellstone as an amendment to "Kassebaum-Kennedy" health insurance reform legislation.<sup>94</sup> By a vote of sixty-eight to thirty,<sup>95</sup> a full-blown, comprehensive parity measure<sup>96</sup> was added to the Senate version of S. 1028, the Health

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91. See John Hendren, *A Parody of Parity: '96 Law Not Much Help to Mentally Ill*, CHI. SUN TIMES, Aug. 12, 1998, at 58 (surveying the limitations of the MHPA and quoting Robert Gabriele, senior vice president of the National Mental Health Association, who stated that "the act has a hole big enough to drive a truck through . . . [and] [i]t isn't real parity"); Christopher Aaron Jones, Note, *Legislative "Subterfuge"?: Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*, 50 VAND. L. REV. 753, 757 (1997) (noting that the MHPA "leaves . . . important limitations [in mental health care coverage] untouched . . ."); cf. 29 U.S.C. § 1185a (1994 & Supp. V 1999) (providing parity just for aggregate annual and lifetime benefit caps), with Domenici/Wellstone Amendment No. 3681, S. 1028, 104th Cong. (1996), 142 CONG. REC. S. 3670 (daily ed. Apr. 18, 1996) (providing for full parity for mental health benefits in all respects). The MHPA that became law was a far less comprehensive measure than the one that originally passed the Senate as an amendment to S. 1028, the "Kassebaum-Kennedy" health care bill. Despite a strong Senate vote for the original, full-scale provision, no mental health provision whatsoever survived Conference Committee negotiations between the House and Senate. See Jones, *supra* note 91, at 767-69.

92. See Jones, *supra* note 91, at 766-69 (discussing Domenici's and Wellstone's efforts to pass parity legislation).

93. See 142 CONG. REC. S9386 (daily ed. Aug. 1, 1996) (referring to the fierce opposition to full parity from certain sectors and quoting Senator Simpson (R-WY) as stating "I am especially troubled that some of the interest groups—boy, have they been sharpening their fangs in this session . . . I have felt a little of it—have been so aggressive in lobbying against [parity]."); see also *Small Business Backs Health Care Compromise*, U.S. Newswire, June 19, 1996, LEXIS Library, U.S. Newswire File (containing the statement of Jack Faris, President of the National Federation of Independent Business). "Any form of the mental health provision is a poison pill to the health care compromise." See *id.*

94. See 142 CONG. REC. S3592 (daily ed. Apr. 18, 1996) (containing the floor vote for the original parity amendment); see also 54 CONG. Q. (BNA) 1077, 1077 (1996) (discussing the surprising defeat of Senator Kassebaum's motion to table the original Domenici/Wellstone amendment).

95. See *id.*

96. See H.R. 3108, § 305(b), 104th Cong. (Apr. 23, 1996) (requiring equality between mental health benefits and medical/surgical benefits in annual and lifetime dollar limits, inpatient hospital days and outpatient doctor visits, and coinsurance

Insurance Portability and Protection Act (“HIPPA”).<sup>97</sup> However, no parallel provision existed in the House version of HIPPA, making the Domenici parity amendment a prime target during conference negotiations between the House and Senate.<sup>98</sup>

The two main arguments raised in opposition to the mental health parity are: (1) that parity is a benefit mandate; and (2) that parity will raise the cost of coverage.<sup>99</sup> According to these arguments, any cost increase within an employer-provided voluntary health insurance market would result in corresponding reductions in coverage.<sup>100</sup> In the voluntary market, parity legislation is particularly vulnerable to the assertion that, given the choice between increasing cost of parity mental health coverage or simply dropping mental health coverage altogether, many group health plans would choose the latter, thereby increasing the number of individuals with no mental health benefits whatsoever.<sup>101</sup> At the time of the amendment, numerous competing

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rates).

97. *See id.*

98. *See Senate Passes Kassebaum-Kennedy, Setting Stage for Conference with the House*, 5 HEALTH L. REP. (BNA) 629, 629 (Apr. 25, 1996) (statement of Senate Majority Leader Robert Dole) [hereinafter Dole Statement] (remarking “[that the Domenici/Wellston Amendment is] a very, very expensive provision, and it’s going to cause all kinds of problems.”).

99. Essentially, these two issues are the same argument, i.e. that benefit mandates will raise costs. *See* Bureau of National Affairs, *Employers Groups Study Bolsters Claims of Negative Side of Mental Health Parity*, 4 HEALTH CARE POL. REP. (BNA) 995, 995 (June 10, 1996) (reporting that a study commissioned by employer groups estimated that parity would result in an 8.7% increase in overall health plan costs, reducing the number of insured Americans by 1.7 million and costing \$20 billion in Federal revenues). *But see* Coopers & Lybrand, *An Actuarial Analysis of the Domenici-Wellstone Amendment to S. 1028, “Health Insurance Reform Act” to Provide Parity for Mental Health Benefits Under Group and Individual Insurance Plans* (for the American Psychological Association) (n.p. Apr. 1996) (estimating a 3.2% increase in premiums attributable to the provision); Milliman & Robertson, *Premium Rate Estimates for a Mental Illness Parity Provision to S. 1028, The Health Insurance Reform Act of 1996* (n.p. Apr. 1996) (estimating a 3.9% increase in costs); Congressional Budget Office, *CBO’s Estimates of the Impact on Employers of the National Mental Health Parity Amendment in H.R. 3103*, Washington, D.C., May 1996 (projecting a 4% increase in costs); Mathematica Policy Research, *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, (for the Substance Abuse and Mental Health Services Administration), Washington, D.C., Mar. 1998 (estimating a 3.6% increase on average).

100. *See Federal Mental Health Parity Legislation: Hearings Before the Senate Committee on Health, Education, Labor and Pensions*, 106th Cong. 2 (2000) (testimony of Dean Rosen, Health Insurance Association of America) [hereinafter Rosen Testimony] (discussing estimates that each one percent increase in insurance costs results in 200,000 to 300,000 fewer covered lives), available at <http://labor.senate.gov/Hearings/may00hr/051800wt/05180jnj/05180emk/domenici/rosen/rosen.htm>.

101. *See* Gail A. Jensen, Ph.D. & Michael A. Morrisey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance*, Study Commissioned by the Health Insurance Association of America (Jan. 1999) (showing that state mandates in Virginia led to twenty-one percent of claims; in Maryland eleven to twenty-two percent of claims; in Massachusetts, thirteen percent of claims; and Idaho and Iowa, five percent of claims, respectively), available at <http://www.membership.hiaa.org/pdfs/>

actuarial estimates of the cost of parity played heavily into Conference Committee deliberations, and concerns over the cost of the provision ultimately led to its demise.<sup>102</sup>

After rejection of the initial, far-reaching parity amendment in Conference,<sup>103</sup> the bill's sponsors scaled back the scope and cost of the provision<sup>104</sup> and made several attempts to attach a fallback version to the final HIPPA Conference Agreement.<sup>105</sup> Despite dramatically reducing the parity amendment's scope, requirements, and cost,<sup>106</sup> the parity amendment was rejected by the Conferees.<sup>107</sup> Angered at this result, parity sponsors vowed to bring parity back to the Senate floor,<sup>108</sup> and successfully offered the fallback version as an amendment to the Veterans Affairs/Housing and Urban Development Appropriations (VA-HUD) bill in the waning days of the 104th Congress.<sup>109</sup> Ultimately, the amendment was later signed into law as the 1996 MHPA.<sup>110</sup>

The 1996 MHPA was a landmark for mental health advocates and

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jensenrpt.pdf (last visited Oct. 18, 2000).

102. See Dole Statement, *supra* note 98 (arguing that the parity amendment should be removed); see also *supra* note 99 (surveying the numerous cost estimates circulating at the time of the MHPA's consideration).

103. See Steve Langdon, *Kennedy, Kassebaum Steer Insurance Bill to Safety*, 54 CONG. Q. (BNA) 2197, 2197 (1996) (discussing the Conferees' efforts to remove mental health parity due to strenuous objection by some Members and the business community).

104. See *id.* Compare Domenici-Wellstone Amendment No. 3681, S. 1028, 104th Cong. (1996), 142 CONG. REC. S3670 (daily ed. Apr. 18, 1996), with Mental Health Parity Act of 1996, Pub. L. No. 104-204, § 702(a), 110 Stat. 2944 (Sept. 26, 1996) (providing for far less protection for the mentally ill than the earlier, more complete version passed as an amendment to the "Kassebaum-Kennedy" health care bill).

105. See Shannon, *supra* note 77, at 97 (acknowledging the 1996 MHPA sponsors' willingness to proffer less comprehensive and expensive parity measures to the Conference Committee).

106. See discussion *supra* Part I.C-D (discussing the opposition in Congress concerning mental health parity reform).

107. See Shannon, *supra* note 77, at 98 (stating that when the Conference Committee on HIPPA finished, mental health parity had been eliminated).

108. See 142 CONG. REC. S9292 (July 31, 1996) (containing Senator Domenici's sentiments on the failure to include any mental health parity provision in the Conference agreement). "I say publicly now . . . and I do not say this very often—but '[s]hame, shame on you.'" See *id.* See also Eric Schmitt, *Wages and Health Lead the Agenda as Congress Acts*, N.Y. TIMES, Aug. 3, 1996, at A1 (containing Domenici's vow that "this issue is not going away").

109. See Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, Pub. L. No. 104-204, 110 Stat. 2974 (Sept. 26, 1996); see also *House Asks Conference to Back Senate Health Measures*, NAT'L J. CONG. DAILY, Sept. 11, 1996 (describing the vote of 392-17 in a non-binding motion to instruct the conferees to acquiesce to the Senate health amendments), available at 1996 WL 10091427.

110. See Departments of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, Pub. L. No. 104-204, 110 Stat. 2974 (Sept. 26, 1996); see also 29 U.S.C. § 1185a(a) (1994 & Supp. V 1999).

consumers,<sup>111</sup> yet the limitations discussed above demonstrate the need for increased protections.<sup>112</sup> Moreover, the looming “sunset” date<sup>113</sup> provides additional impetus for new legislation. Fortunately, legislation currently exists that moves these protections forward, and does so in an effective, appropriate manner.<sup>114</sup>

## II. Managing Parity: Senate Bill 543—The Mental Health Equitable Treatment Act of 2001

### A. *The Nexus of Cost and Coverage in a Voluntary System*

Today, a majority of Americans with private health care coverage receive such benefits from their employer.<sup>115</sup> As the cost of health care coverage has increased<sup>116</sup> it has become clear that the overall number of “covered lives” is related to fluctuations in the cost of such coverage.<sup>117</sup> Specifically, projections suggest that every one percent increase in premiums increases the number of uninsured Americans by 200,000 to 300,000.<sup>118</sup> Further, there is evidence that coverage mandates have discernable impacts on the cost of health insurance.<sup>119</sup>

Against this backdrop, any legislation mandating certain benefits must be aware of the overall cost and coverage impacts concomitant with the mandate.<sup>120</sup> This cost awareness is no less true for mental health services. A 1990 study found that, among state benefit

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111. See Pear, *supra* note 82, at A1 (containing statement of Senator Domenici that the 1996 MHPA represents “a historic step, a breakthrough, for the severely mentally ill”).

112. See discussion *supra* Part I.C (addressing the limitations of the 1996 MHPA).

113. See *supra* note 90 and accompanying text (providing the “sunset” date of the 1996 MHPA at Sept. 30, 2001).

114. See discussion *infra* Part II (discussing S. 543’s legislative approach).

115. See McGuire, *supra* note 4, at 4 (asserting that sixty percent of Americans are covered by private health insurance).

116. See *Moderate Rise in Employer Health Costs Not Likely to Last*, Foster Higgins Says, 5 HEALTH CARE POL. REP. (BNA) 158, 158 (Jan. 1997) (covering past cost increases and predicting sharper increases than those experienced in 1996).

117. See Rosen Testimony, *supra* note 98 (discussing the impact on covered lives of increases in health premiums).

118. See *id.* (noting that the Congressional Budget Office estimated that a one percent increase in premiums would increase the number of uninsured Americans by 200,000 in 1996, but since that time, private economists have estimated a coverage lost rate of 300,000 Americans for every one percent increase in premium cost).

119. See Gail A. Jensen, Ph.D. & Michael A. Morrissey, *Mandated Benefit Laws and Employer-Sponsored Health Insurance*, Study Commissioned by the Health Insurance Association of America, (Jan. 1999), available at <http://www.hiaa.org/news/news-state/jensen.htm> (last visited Sept. 15, 2001) (discussing which benefits were found to increase costs by the greatest percentages).

120. See *id.* (showing that increased medical benefit costs are offset either through increased costs to employee-beneficiaries, reductions in employee compensation or reductions in the number of employees electing to purchase coverage).

mandates, inpatient psychiatric hospital stays increased the cost of coverage by thirteen percent, and psychologist visit benefits increased costs by twelve percent.<sup>121</sup> Despite our predictions of runaway cost increases associated with a parity provision during the 1996 debate,<sup>122</sup> insurance claims and cost data accumulated since the provision's implementation have shown that parity coverage is not prohibitively expensive.<sup>123</sup> A General Accounting Office study of the implementation and effects of the 1996 MHPA found that thirty-seven percent of surveyed employers reported no increase in claims costs attributable to their implementation of the MHPA, and only three percent of respondents suggested any increase in costs.<sup>124</sup> Additionally, less than one percent of employers dropped mental health coverage altogether as a result of the MHPA.<sup>125</sup>

Such cost data, however, does not provide a full picture of the effect of the 1996 MHPA on the provision of mental health benefits coverage.<sup>126</sup> One significant result of the 1996 MHPA mandate was the institution of more restrictive plan features by insurers.<sup>127</sup> Almost two-thirds of newly-compliant employers<sup>128</sup> adopted at least one additional restriction on mental health benefits to offset the 1996 MHPA's mandate,<sup>129</sup> resulting in eighty-seven percent of compliant plans containing additional mental health benefit restrictions.<sup>130</sup>

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121. *See id.* (showing that state mandates in Virginia led to twenty-one percent of claims; in Maryland eleven to twenty-two percent of claims; in Massachusetts, thirteen percent of claims; and Idaho and Iowa, five percent of claims, respectively).

122. *See Employer Group's Study Bolsters Claims of Negative Side of Mental Health Parity*, 4 HEALTH CARE POL. REP. (BNA) 995 (1996) (surveying cost projections produced at the time of the initial, comprehensive 1996 parity amendment).

123. *See* GAO Letter Report, *supra* note 14, at 16-17 (finding that "[s]everal studies aimed at estimating the costs of the federal parity law concluded that requiring parity limits would result in cost increases of less than 1 percent.").

124. *See id.* at 16 (noting, however, that compliance with the MHPA was associated with increased restrictions in other plan features, such as higher copays and deductibles and limited outpatient visits and inpatient hospital days).

125. *See id.* at 17.

126. *See id.* at 13 (concluding that employers who adopted the federal parity requirements were more likely to restrict access to mental health coverage by "tightening other design features" than those employers who did not change the dollar limits).

127. *See id.* (noting that the most common restrictive changes were limitations on outpatient office visits and hospital days).

128. *See id.* at 5 (using the term "newly-compliant" to reference those employers whose plans did not meet the 1996 MHPA's coverage requirements prior to its enactment).

129. *See id.* at 13 (finding that "[a]bout 65 percent . . . of employers that adopted annual of lifetime parity in dollar limits after 1996 changed at least one other mental health design feature to a more restrictive one.").

130. *See id.* at 12 tbl. 3 (listing the restrictive elements of mental health benefit plan design). Almost two-thirds of plans with 1996 MHPA mandated coverage provide fewer inpatient hospital days and outpatient visits. *See id.*

Consequently, any new mental health benefit mandate must expand benefits for the insured while allowing insurers to manage the benefits and control costs, without reducing the number of covered lives.<sup>131</sup>

*B. The Federal Employee Health Benefits ("FEHB") Program and the Washington Business Group on Health ("WBGH")*

On June 7, 1999, during remarks at the White House Conference on Mental Health, President Clinton announced Executive Order 13,124,<sup>132</sup> directing the Office of Personnel Management ("OPM") to implement parity benefits for federal employees enrolled in the Federal Employee Health Benefit ("FEHB") program.<sup>133</sup> In response, OPM contracted with the Washington Business Group on Health ("WBGH"),<sup>134</sup> a member organization with nearly 150 large employer members, to assist in assessing members' experiences and best practices in providing mental health care, and to analyze the recommendations of large employers currently providing generous or parity mental health coverage.<sup>135</sup> Based largely on these employers' experiences and input,<sup>136</sup> OPM instructed participating

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131. See *id.* at 21 (recommending that Congress consider state laws requiring parity both in service limits and cost-sharing requirements to determine the potential cost of extending parity to alleviate the "restrictions . . . that may have offset the parity achieved in dollar limits.").

132. See Exec. Order No. 13,124, 3 C.F.R. 192 (1999), *reprinted in* 5 U.S.C. § 3301 (1994 & Supp. V 1999). The order states:

The Office of Personnel Management (OPM) and the President's Task Force on Employment of Adults with Disabilities believe that the Federal Government could better benefit from the contributions of persons with psychiatric disabilities if they were given the same opportunities available to people with mental retardation or severe physical disabilities.

*Id.* § 1(c).

133. See Remarks at the White House Conference on Mental Health, PUB. PAPERS 894 (June 7, 1999). The President stated: "I am using my authority as President to ensure that . . . the Federal Employee Health Benefit Plan . . . provides full parity for mental health . . . they [health plans participating in FEHBP] must provide equal coverage for mental and physical illnesses." *Id.* at 896.

134. See Kristen Reasoner Apgar, *Report to the Office of Personnel Management, Large Employer Experiences and Best Practices in Design, Administration, and Evaluation of Mental Health and Substance Abuse—A Look at Parity in Employer-Sponsored Health Benefit Programs* (Mar., 2000), available at [www.opm.gov/insure/mental/](http://www.opm.gov/insure/mental/) (last visited Nov. 5, 2001) [hereinafter Report to OPM] (containing information provided by American Airlines, AT&T, Delta Air Lines, Eastman Kodak, General Motors, IBM, the Massachusetts Group Insurance Commission and Pepsico).

135. See *id.* at 1 ("The aim was to provide OPM with suggestions, examples and analysis that may assist it as it moves forward with its parity initiative.").

136. See Janice R. Lachance, *Memorandum for Personnel Directors of Executive Departments and Agencies: Mental Health and Substance Abuse Parity Implementation in the Federal Employees Health Benefits (FEHB) Program* (July 13, 2000) (stating that "[t]he [WBGH] report helped us immeasurably to clarify issues and refine our approach."), available at [http://www.opm.gov/insure/health/parity/071300\\_mental\\_health.htm](http://www.opm.gov/insure/health/parity/071300_mental_health.htm)

FEHB plans to “provide network parity coverage for all diagnostic categories of mental health and substance abuse conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*” beginning with the 2001 contract year.<sup>137</sup> OPM explicitly stated that “[t]he overriding goal of parity is to expand the range of benefits offered while managing costs effectively”<sup>138</sup> and they “encouraged health plans to manage mental health . . . care in order to [meet these ends].”<sup>139</sup> The key to the approach chosen by OPM was that parity “can be introduced, using appropriate care management . . . delivered in a fully coordinated managed behavioral health environment that incorporates techniques such as case management, authorized treatment plans, gatekeepers and referral mechanisms, contracting networks, pre-certification of inpatient services, concurrent review, discharge planning, [and] retrospective review and disease management.”<sup>140</sup>

### C. *Quality Sacrificed in the Name of Parity?*

The emphasis OPM placed on cost management, and the specter of an increasing role for managed care in providing mental health services, raises concerns regarding access to quality, appropriate treatment.<sup>141</sup> Despite those concerns, however, the experiences of

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(last visited Sept. 9, 2001).

137. See *id.* at “attachment” (providing that “[p]arity in the FEHB program means coverage for mental health, substance abuse, medical, surgical, and hospital services will be identical with regard to traditional medical care deductibles, coinsurance, copays and day and visit limitations.”).

138. *Id.* at attachment.

139. *Id.*

140. Report to OPM, *supra* note 134, at 1 (quoting FEHB Program Carrier Letter No. 1999-027, Mental Health and Substance Abuse Parity (June 7, 1999), available at <http://www.omp.gov/insure/health/parity/99-027.pdf>). Certainly, this approach is susceptible to broad-side attacks on the methods and procedures utilized under managed care scenarios generally. However, employer experiences have demonstrated that comprehensive, properly coordinated and managed behavioral health care can not only expand benefits and hold costs in check or reduce them, but also produce other savings in terms of employee productivity, reduced absenteeism, and reduced disability claims. See discussion *supra* at Part II.C (discussing some of the practical results of the implementation of mental health parity on health plan and employee experience).

141. See Report to OPM, *supra* note 134, at 2 (detailing the “essential mechanisms utilized to manage quality of care [as]: preferred networks; pre-approval of treatment; a full continuum of treatment settings in the networks; referral mechanisms to connect employees to correct services; [and] utilization review and financial accountability.”); see also Alan J. Otten, *Mental Health Parity: What Can It Accomplish in a Market Dominated by Managed Care* (June 1998), available at <http://www.milbank.org/mrparity.html> (quoting Harvard University’s Richard Frank as observing that “[m]anaged care drives a wedge between the nominal benefit, what the plan provides, and the effective benefit, what the patient actually gets.”) (last visited Sept. 7, 2001) (on file with the *American University Law Review*). See

participating WBGH members<sup>142</sup> demonstrated that employers with large employee/beneficiary populations<sup>143</sup> can “move to expanded, parity or near-parity benefits, *improve* the quality of care, and contain or reduce costs.”<sup>144</sup> For instance, one employer<sup>145</sup> found that before the implementation of managed parity, employees were being disproportionately treated in high-cost inpatient settings, but were not treated prior to hospitalization and did not receive outpatient follow-up services.<sup>146</sup> After implementing a managed care behavioral health “carve-out,”<sup>147</sup> inpatient costs dropped forty-six percent and outpatient costs decreased by twenty-one percent<sup>148</sup> despite more employees accessing and utilizing more services.<sup>149</sup> A recent National Advisory Mental Health Council (“NAMHC”) study found that implementation of managed parity by a large employer group (over 150,000 employees) reduced per-member costs by half while the proportion of employees accessing mental health services actually

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generally Harold E. Varmus, M.D., *Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality, An Interim Report to Congress by the National Advisory Mental Health Council 24* (May 1998) (noting “considerable concerns—but little systematic evidence—about how [managed care] affect[s] both access to care and quality of care for patients.”).

142. See Report to OPM, *supra* note 134, at 10 (explaining why certain employers were chosen). This report states that:

[such employers were selected] because they: Provide generous mental health and substance abuse benefits that meet or approach parity standards; Have experience in evaluating benefit plan quality and performance; Employ successful employee communication programs; Have relevant experience in addressing behavioral health plan transitions; Provide benefits to a large number of employees and their families; Have worksite locations throughout the country; and Represent a variety of industry groups.

*Id.*

143. See Report to OPM, *supra* note 134, at 10-11 (stating that the participating employers employ roughly 1.23 million employees, with approximately 2.4 million covered lives overall).

144. *Id.* at 12 (explaining that many of these same employers previously used higher co-pays and deductibles and other traditional benefit limitations to control the costs associated with the provision of mental health benefits) (emphasis added).

145. See *id.* at 11 n.3 (explaining that employers were identified by letter, i.e. “employer A,” or “employer B” due to employer concerns about the proprietary/competitive nature of some of the reported data).

146. See *id.* at 13 (explaining that this was particularly true for adolescents).

147. See Brandi White, *Mental Health Care: From Carve-out to Collaboration*, available at <http://www.aafp.org/fpm/970900fm/lead.html> (last visited Nov. 5, 2001) (describing a “carve-out” as “arrangements that pull mental health care completely out of the scope of family practice and other primary care specialties and place it in the hands of separate mental health care companies.”). This American Academy of Family Physicians’ report states that carve-outs cover over 120 million Americans. *Id.* at 2.

148. See Report to OPM, *supra* note 134, at 13 (noting that there was no increase in re-admission rates).

149. See *id.* at 13 (stating that the driving factor for this particular employer’s choice of provider network was quality of care).



increased.<sup>150</sup>

Similarly, other studies show parity can lead to reduced costs in other areas. A 1998 joint study by UNUM Life Insurance Company and Johns Hopkins University found reduced psychiatric disability claims costs when employees had access to outpatient mental health services.<sup>151</sup> Likewise, employers providing plans with high deductibles for mental health services experienced “substantially higher rates of psychiatric disability claims, increased duration of disability, and decreased likelihood of employees’ returning to work.”<sup>152</sup>

Thus, there is little indication that a properly structured and managed mental health benefit actually leads to less care, less appropriate care, or less desirable outcomes.

#### D. Senate Bill 543—Managing Parity

Senate Bill 543 (“S. 543”), the Mental Health Equitable Treatment Act of 2001,<sup>153</sup> parallels the OPM directive,<sup>154</sup> preventing group health plans from “impos[ing] any treatment limitations<sup>155</sup> or financial requirements<sup>156</sup> with respect to the coverage of benefits for mental illness unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits.”<sup>157</sup> Like the OPM directive, S. 543 defines “mental health benefits” as

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150. See Ruth L. Kirschstein, M.D., *Insurance Parity for Mental Health: Cost, Access, and Quality, Report to Congress by the National Advisory Mental Health Council*, NIH Publ’n No. 00-4787, at 12 (June 2000) (finding that “compared with the pre-parity period, per-member costs were halved . . . while the proportion of the population receiving some mental health services increased” over a three-year period at a major employer group).

151. See Report to OPM, *supra* note 134, at 7 (citing D. Salkever, *Predictors and Descriptors of Psychiatric Duration, Cost and Outcomes Study* (UNUM Life Insurance Co.) (1998), and Richard G. Frank et al., *The Value of Mental Health Care at the System Level*, HEALTH AFFAIRS 18 (5), at 71-88 (1999)).

152. Varmus, *supra* note 141, at 31 (quoting D. Salkever, *Psychiatric Disability in the Workplace*, INSIGHT (5), at 1 (UNUM Disability Lab, UNUM Life Insurance Co. of America) (1998)).

153. S. 543, 107th Cong. (2001), *supra* note 25.

154. See discussion *supra* Part III.B.

155. See S. 543 § (2)(e)(4) (amending ERISA § 712, 29 U.S.C. § 1185(a)) (defining “treatment limitations” as “limitations on the frequency of treatment, number of visits or days of coverage, or other limits on the duration or scope of treatment under the plan or coverage.”).

156. See *id.* § (2)(e)(1) (amending ERISA § 712, 29 U.S.C. § 1185(a)) (defining “financial requirements” to include “deductibles, coinsurance, co-payments, other cost sharing, and limitations on the total amount that may be paid with respect to benefits under the plan or health insurance coverage with respect to an individual or other coverage unit [including annual and lifetime limits.]”).

157. *Id.* § (2)(e)(2) (amending ERISA § 712, 29 U.S.C. § 1185(a)) (defining “medical or surgical benefits” as “benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but [not including] mental health benefits.”).

“benefits with respect to services for all categories of mental health conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV)*, or the most recent edition if different than the Fourth Edition.”<sup>158</sup> Further, S. 543 constrains overall utilization by providing parity only if “such services are included as part of an authorized treatment plan that is in accordance with standard protocols[,] and such services meet applicable medical necessity criteria.”<sup>159</sup> Unlike the OPM directive, however, S. 543 further limits cost exposure by explicitly excluding substance abuse and/or chemical dependency from the parity mandate,<sup>160</sup> and does not require health plans to offer mental health benefits.<sup>161</sup>

Senate Bill 543 seeks to capitalize on the experiences of the WBGH members<sup>162</sup> who introduced generous mental health benefits for beneficiaries, but who did so in an atmosphere designed to provide the most appropriate treatment in a cost-effective and efficient manner.<sup>163</sup> Thus far, such benefit designs do not appear to limit access to care or undermine quality in any significant way.<sup>164</sup> In order to acquire more definitive answers to these concerns, S. 543 requires the General Accounting Office (“GAO”) to study and evaluate the impact of S. 543’s implementation on “the cost of health insurance coverage, access to health insurance coverage (including the availability of in-network providers), the quality of health care, and other issues as determined appropriate by the [GAO] Comptroller General.”<sup>165</sup>

As a result, S. 543 represents a balanced, responsible approach to achieving mental health parity. It provides substantial new protections for Americans with a mental illness, allows insurers and

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158. *Id.* § (2)(e)(3) (amending ERISA § 712, 29 U.S.C. § 1185(a)).

159. *Id.* (amending ERISA § 712, 29 U.S.C. § 1185(a)).

160. *See id.* (amending ERISA § 712, 29 U.S.C. § 1185(a)) (stating that S. 543 “[does] not include benefits with respect to the treatment of substance abuse or chemical dependency.”).

161. *See id.* § (2)(b) (amending ERISA § 712, 29 U.S.C. § 1185(a)) (stating that “[n]othing in this section shall be construed as requiring a group health plan (or health insurance offered in connection with such a plan) to provide any mental health benefits.”).

162. *Compare* the size of the eight WBGH companies surveyed, *supra* notes 135, 144 (listing the eight companies participating in the survey, and stating that the number of covered lives overall equaled 2.4 million), *with* S. 543 § (2)(c)(1) (amending ERISA § 712, 29 U.S.C. § 1185(a)) (exempting employers of fifty or less).

163. *See* discussion *supra* Part II.B (listing the common mechanisms used by WBGH member participants to provide parity but manage the overall benefit).

164. *See supra* Part II.C (discussing plan/beneficiary experience under parity managed behavioral health).

165. *See* S. 543 § 5(a)-(b) (requiring the results of the study no later than two years after the date of the act’s enactment).

health benefit plans to appropriately manage benefits and costs, and its GAO study requirement will answer vexing questions about the overall cost and quality of equal benefits in a managed care setting.

### III. HISTORY OF LEGAL BATTLES FOR PARITY

Yet, legislative action is only one part of a two-part strategy to increase legal protections for the mentally ill.<sup>166</sup> The second part of this strategy looks to the courts, seeking to draw unequal health care coverage under the protective aegis of the ADA, making “parity coverage” a legal requirement for certain populations.<sup>167</sup>

“[T]he ADA seeks to ensure access to equal employment opportunities [for the disabled] based on merit.”<sup>168</sup> In the wake of the passage of the ADA, practically every federal appellate circuit in the nation has considered challenges to unequal coverage of mental illness in employee benefit plans brought under its various titles.<sup>169</sup> Although the circuits are divided on some key questions presented,<sup>170</sup>

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166. See discussion *supra* Part II (advocating for Federal legislation mandating mental health parity in a manner similar to that recently implemented in Federal Employee Health Benefit plans).

167. See discussion *infra* Part IV (specifying the requirements for an individual challenge to unequal mental health benefits coverage under ADA Title I protections).

168. Equal Opportunity Employment Commission Interpretive Guidance on Title I of the Americans with Disabilities Act, 29 C.F.R. pt. 1630, app. (2000) [hereinafter EEOC Guidance] (providing background on the ADA and guidance for implementing Title I provisions). “The ADA is a federal antidiscrimination statute designed to remove barriers which prevent qualified individuals with disabilities from enjoying the same employment opportunities that are available to persons without disabilities.” *Id.* at pt. 1630, app.

169. See *EEOC v. Staten Island Sav. Bank*, 207 F.3d 144, 145 (2d Cir. 2000) (holding the EEOC’s practice of providing less long-term disability coverage for mental disabilities than for physical disabilities did not violate Title I of the ADA); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1112 (9th Cir. 2000) (finding that plaintiff was not qualified to sue under Title I of the ADA because plaintiff could not perform essential functions of job due to total disability); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101 (10th Cir. 1999) (asserting that employer’s two-year cap on mental disability benefits does not violate ADA); *Lewis v. Kmart Corp.*, 180 F.3d 166, 171-72 (4th Cir. 1999) (stating that the federal disability statutes are not intended to guarantee equal treatment of all disabilities); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 611 (3d Cir. 1998) (restating position that insurance companies’ unequal treatment of various disabilities does not violate the ADA and requires no justification); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1019 (6th Cir. 1997) (emphasizing that the ADA is designed to prevent discrimination between disabled and non-disabled); *EEOC v. CNA Ins. Co.*, 96 F.3d 1039, 1044 (7th Cir. 1996) (explaining that the employer’s disability plan did not violate the ADA because the plan offered equal access, terms and prices to all employees); *Moddero v. King*, 82 F.3d 1059, 1061 (D.C. Cir. 1996) (referring to Supreme Court’s finding that the ADA allows the handicapped to participate in federal health care but does not guarantee equal results to non-handicapped individuals).

170. Compare *Weyer*, 198 F.3d at 1110 (holding that the plaintiff did not have standing to bring a challenge under Title I of the ADA because she was claiming complete disability, and was therefore unable to perform the “essential functions” of

the overarching conclusion has been that unequal coverage does not constitute illegal discrimination under the ADA.<sup>171</sup>

In reaching this conclusion, federal courts have raised three seemingly insurmountable obstacles. First, several circuits have found that the individuals suing lacked a cognizable claim under the ADA because they were not “qualified individuals” for the purposes of the ADA’s remedial powers.<sup>172</sup> Second, even where the court did find standing under the ADA,<sup>173</sup> the claims still failed because the ADA does not require equality “between types of disabilities,” but requires equality between the disabled and the non-disabled.<sup>174</sup> Therefore, comprehensive coverage of certain disabilities within a long-term disability plan is permissible only if all employees are subject to the same terms and conditions of participation, e.g. equal access to the benefit plan or identical charges for participation.<sup>175</sup> Finally, several

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the job whether with “reasonable accommodation” or not), *with Ford*, 145 F.3d at 607 (declining to follow other circuits, and interpreting Title I of the ADA to “allow disabled former employees to sue their former employers regarding their disability benefits so as to effectuate the full panoply of rights guaranteed by the ADA”).

171. *See Weyer*, 198 F.3d at 1116 (finding no violation of the ADA where all employees are given equal access to health and disability plans); *Ford*, 145 F.3d at 608 (holding that different treatment of mental and physical illness in a long-term disability plan did not violate the ADA).

172. *See Weyer*, 198 F.3d at 1108 (“An ADA plaintiff bears the burden of proving that she is a ‘qualified individual with a disability’ . . . [a] totally disabled person who cannot ‘perform the essential functions of the employment position’ with or without reasonable accommodations cannot be a ‘qualified individual’ entitled to sue under Title I of the Act.” (quoting *Cleveland v. Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 806 (1999))). *See id.*

173. *See Ford*, 145 F.3d at 608 (favoring a “broad temporal interpretation of ‘qualified individual with a disability,’” the *Ford* court disagreed with “sister courts of appeals” in finding that Title I of the ADA does “permit totally disabled individuals to sue their former employers regarding their disability benefits.”).

174. *See id.* at 609 (noting that although the *Ford* court disagreed with earlier decisions denying standing to totally disabled individuals, the court agreed with those decisions’ holdings based on the merits).

175. *Compare* 42 U.S.C. § 12112(a) (1994) (providing under Title I of the ADA that “[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability . . . in regard to . . . terms, conditions, and privileges of employment”), *with Weyer*, 198 F.3d at 1116 (stating, “there is no discrimination under the Act where disabled individuals are given the same opportunity as everyone else, so insurance distinctions that apply equally to all employees cannot be discriminatory”). *Accord Ford*, 145 F.3d at 608 (asserting that requiring the same benefits for each disability would destabilize the insurance industry, which is an outcome likely not intended by Congress); *EEOC v. CNA Ins. Co.*, 96 F.3d 1039, 1044 (7th Cir. 1996) (explaining that employer offered pension plan that did not differ in terms, cost or availability between disabled and non-disabled, and that without stronger language in the ADA, the court is reluctant to read statute too broadly); *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674, 678 (8th Cir. 1996) (holding that the exclusion of infertility treatments from an employee’s medical benefits did not constitute discrimination). Citing unequal mental health benefits as an example, the *Krauel* court concluded:

Broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without

courts have conspicuously noted the legislative and judicial histories of the Rehabilitation Act,<sup>176</sup> the ADA,<sup>177</sup> and the 1996 MHPA,<sup>178</sup> reasoning that, had Congress intended for the ADA to require equal treatment between benefits for mental and physical illness, Congress would have explicitly said so.<sup>179</sup>

The decisions erecting the standing and “equal access to unequal plans” obstacles find roots in earlier Supreme Court decisions, which apply analogous provisions of the Rehabilitation Act, the ADA’s precursor,<sup>180</sup> to cases involving unequal disability benefits.<sup>181</sup> In

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disabilities, are not distinctions based on disability . . . although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA.

*Krauel*, 95 F.3d at 678.

176. See Rehabilitation Act of 1973, 29 U.S.C.A. § 794 (West 1998 & Supp. 2000); 29 U.S.C. § 794(a) (1994) (constituting the pre-cursor of the ADA, though applicable mainly to government programs and activities). Section 504 states: “No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of his or her disability, be excluded from . . . participation in, be denied the benefits of, or be subjected to discrimination under any program or activity . . . conducted by any Executive agency.” *Id.* See also *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1102 (10th Cir. 1999) (citing to *Bragdon v. Abbott*, 524 U.S. 624 (1998); *Moddero v. King*, 82 F.3d 1059, 1061 (D.C. Cir. 1996)) (finding that “[b]ecause the language of the ADA mirrors that in the Rehabilitation Act, we look to cases construing the Rehabilitation Act for guidance”). In *Moddero*, the D.C. Circuit rejected a challenge of unequal disability benefits for mental health brought under the Rehabilitation Act, stating “distinctions between mental and physical care are no more vulnerable under § 540 than are completely generalized limits.” See *Moddero*, 82 F.3d at 1062.

177. See *EEOC v. Staten Island Sav. Bank*, 207 F.3d 144, 146 (2d Cir. 2000) (indicating hesitance to stretch the ADA beyond its typical interpretation). The court stated that:

The ADA, unclear on its face, does not specifically condemn the historic and nearly universal practice inherent in the insurance industry of providing different benefits for different disabilities . . . [o]f course, Congress would require those modifications to be made, but we are reluctant to infer such a mandate for radical change absent a clearer legislative command.

*Id.* at 149.

178. See *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1017 (6th Cir. 1999) (referring to the rejection of the original MHPA from health care reform legislation in 1996). The court remarked that:

Few, if any mental health advocates have thought that the result they would like to see [parity required under the ADA] has been there all along in the ADA. This is well illustrated by the debate over a proposed amendment to the Health Insurance Portability and Accountability Act of 1996. The amendment, [the MHPA] which was defeated before final passage of the bill, would have required parity of coverage for mental and physical conditions. This debate reinforces our conclusion based on the language of the ADA that the issue of parity among physical and mental health benefits is one that is still in the legislative arena.

*Id.*

179. See *id.*

180. See *Lewis v. Kmart Corp.*, 180 F.3d 166, 171 (4th Cir. 1999) (asserting that Title I of the ADA is the “sister provision” of § 504(a) of the Rehabilitation Act, and that the anti-discrimination language parallels each other).

181. See *Traynor v. Turnage*, 485 U.S. 535, 549 (1988) (citing to 1977 Department

*Traynor v. Turnage*,<sup>182</sup> the Supreme Court denied an attempt to overturn a Veterans' Administration regulation denying extended GI Bill education benefits to veterans whose alcohol-related disability was the result of "willful misconduct," but allowed the extension for individuals whose alcoholism was caused by an underlying mental illness.<sup>183</sup> The Court stated, "[t]here is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons."<sup>184</sup> Similarly, in *Alexander v. Choate*,<sup>185</sup> the Supreme Court found that a Tennessee Medicaid provision limiting the number of covered inpatient hospital days was not discriminatory under the Rehabilitation Act.<sup>186</sup> Although the provision disproportionately impacted the disabled, the provision was technically non-discriminatory because all Medicaid beneficiaries had equal access to the benefit.<sup>187</sup> Courts considering challenges to unequal disability benefits brought under the ADA have relied significantly on *Traynor* and *Alexander* for guidance in their decisions,<sup>188</sup> and have roundly decided that the legislative and judicial pedigrees of the Rehabilitation Act and the ADA preclude their application in a way that broadly declares unequal benefits illegally discriminatory.<sup>189</sup> Based solely on these decisions, the route to equal

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of Health, Education and Welfare regulations stating that the "exclusion of a specific class of handicapped persons from a program limited by federal statute or executive order to a different class of handicapped persons is not prohibited"); *Alexander v. Choate*, 469 U.S. 287 (1985).

182. *See id.*

183. *See id.* at 550 (noting that the GI Bill does not deny benefits to all alcoholics but only those whose drinking is not rooted in a mental illness).

184. *Id.*

185. 469 U.S. 287 (1985).

186. *See id.* at 287 (explaining that state does not have to provide more coverage for the disabled, and that the ADA does not require state to vary coverage between illnesses).

187. *See id.* at 302 (finding that "[t]he reduction in inpatient coverage will leave both handicapped and nonhandicapped Medicaid users . . . subject to the same duration limitation."). The reduction in covered inpatient days, the Court found, was "neutral on its face." *Id.*

188. *See Lewis*, 180 F.3d at 171 (noting the Supreme Court's decision in *Traynor*, the *Lewis* court stated that the Supreme Court "has never held that it is unlawful under the ADA or the Rehabilitation Act to give preferential treatment to one disability over another"); *see also Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998) (applying the Supreme Court's reasoning in *Alexander* and finding that "handicapped citizens did not suffer from discrimination because both handicapped and non-handicapped individuals were 'subject to the same durational limitation.'").

189. *See Lewis*, 180 F.3d at 171 (asserting that federal statutes are not designed to treat all disabilities the same); *see also Ford*, 145 F.3d at 608 (noting that the ADA does not require equal coverage for all disabilities, which would destabilize insurance industry).

treatment of mental illness through the ADA appears foreclosed.<sup>190</sup>

#### IV. TITLE I OF THE ADA AND A CASE-BY-CASE STRATEGY

While there is virtual unanimity among the circuits that the blanket unequal treatment of mental illness in employee benefit plans does not constitute a violation of the ADA,<sup>191</sup> the state of ADA law regarding individualized job discrimination claims is still evolving.<sup>192</sup> Instead of attempting to achieve an overarching judicial declaration that unequal coverage is presumptively discriminatory,<sup>193</sup> mental health advocates should consider an individualized legal approach. Chief among the areas of evolving ADA case law which could prove fertile soil for mental health advocates is the doctrine of “reasonable accommodation” made to an employee with a disability.<sup>194</sup>

Essentially, the reasonable accommodation doctrine requires employers to take reasonable steps to accommodate their disabled employees.<sup>195</sup> Yet, as of this date, no case has been brought seeking equal benefits for mental illness on the basis that providing such coverage would be a “reasonable accommodation” by an employer to allow an employee to continue working. The approach utilizing the reasonable accommodation doctrine does not broadly challenge the underlying benefits structure, but instead addresses the

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190. See discussion *supra* Part III (including adverse decisions from a majority of Federal circuits for individuals challenging unequal benefits for mental illness).

191. See *Staten Island Sav.*, 207 F.3d at 144; *accord Weyer*, 198 F.3d at 1104; *Kimber*, 196 F.3d at 1092; *Lewis*, 180 F.3d at 166; *Ford*, 145 F.3d at 601; *Parker*, 121 F.3d at 1006; *CNA Ins.*, 96 F.3d at 1039; *Modderno*, 82 F.3d at 1059.

192. Compare *James v. Frank*, 772 F. Supp. 984, 997 (S.D. Ohio 1991) (holding that the provision of a chair with wheels and arms for an above-the-knee amputee was not an unreasonable accommodation and did not impose undue hardship on his employer, the U.S. Postal Service), with Regulations to Implement the Equal Employment Opportunity Provisions of the Americans with Disabilities Act, 29 C.F.R. § 1630.2(o)(2)(i) (1996) (stating that the obligation to make reasonable accommodation does not apply to providing wheelchairs or eyeglasses).

193. See discussion *supra* Part III (discussing various cases in which courts have repeatedly ruled that unequal treatment benefits between disabilities does not qualify as discrimination under the ADA).

194. See discussion *infra* Part IV.A-D (discussing the criteria that must be met in order to receive the protection of Title I of the ADA by claiming that an employer has failed to provide reasonable accommodations).

195. See 42 U.S.C. § 12111(9) (1994).

The term, “reasonable accommodation” may include—

(A) making existing facilities used by employees readily accessible to and useable by individuals with disabilities; and

(B) job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials, or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

*Id.*

individualized effects of such unequal coverage on a case-by-case basis, with the ultimate goal of obtaining necessary medical treatment.<sup>196</sup> By framing the issue as a measure to allow an individual to keep working, this approach helps accomplish one of the mental health community's most important and enduring goals—proving that with equal and fair treatment, people with mental illness can function like any other member of society.<sup>197</sup>

Of course, to obtain relief on an individualized basis, numerous legal hurdles must be cleared and additional criteria satisfied.<sup>198</sup> The following section provides a generalized framework for the main questions raised in “reasonable accommodation” cases, then discusses the *prima facie* requirements for individualized employment discrimination cases under Title I of the ADA.<sup>199</sup> Finally, the section applies reasonable accommodation jurisprudence to a hypothetical real-world scenario, bringing the individualized effects of unequal mental health benefits within the protective realm of Title I of the ADA.<sup>200</sup>

#### A. *The ADA—Title I*

Title I of the ADA regulates employment practices, and states: “[n]o covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.”<sup>201</sup> In order for a person to

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196. See discussion *infra* Part IV.F (arguing that the key to battling fewer benefits for mentally ill is to focus on the issue of continued employment, thereby drawing-in ADA Title I protections).

197. See Domenici Statement, *supra* note 10, at 3001 (asserting that the MHPA has the very simple goal of providing treatment for the mentally ill commensurate with other illnesses).

198. See discussion *infra* Part IV (discussing the elements of qualified individuals, reasonable accommodation and undue hardship).

199. See discussion *infra* Part IV (arguing that individual employment discrimination cases are more successful in battling mental illness discrimination).

200. See discussion *infra* Part IV.F (using a hypothetical to demonstrate a potential Title I lawsuit where the plaintiff argues that the refusal to provide equal benefits acts as an unreasonable impediment to continued employment).

201. See 42 U.S.C. § 12112(b)(1) (1994) (defining discrimination as, “limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee.”). The ADA contains four main titles: Title I, 42 U.S.C. §§ 12111-12117 (1994) (regulating private sector employment practices); Title II, 42 U.S.C. §§ 12131-12165 (1994) (stating application to state and local governments); Title III, 42 U.S.C. §§ 12181-12189 (1994) (regulating places of public accommodation and commercial facilities provided by private actors); and Title IV, 42 U.S.C. §§ 12201-12213 (1997) (regulating numerous miscellaneous areas such as construction, state immunity, prohibition against retaliation and coercion,



be protected by Title I of the ADA they must be: (1) a “qualified individual” with a disability;<sup>202</sup> (2) who can perform the essential duties of the position with or without the employer making a “reasonable accommodation;”<sup>203</sup> and (3) the reasonable accommodation cannot impose an “undue hardship” on the employer.<sup>204</sup> The following subsections analyze these requirements individually and provide a survey of “reasonable accommodation” precedent.

### B. *Qualified Individual*

First, a plaintiff must be a “qualified individual with a disability.”<sup>205</sup>

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regulations by the Architectural and Transportation Barriers Compliance Board, attorney’s fees, technical assistance).

202. See 42 U.S.C. § 12111(8) (1994) (defining “qualified individual with a disability”). This definition states that:

[A]n individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. For the purposes of this title, considerations shall be given to employer’s judgement as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing for the job, this description shall be considered evidence of the essential functions of the job.

*Id.*

203. See 42 U.S.C. § 12111(9) (1994) (defining “[r]easonable accommodation”). This definition states that reasonable accommodation is:

making existing facilities used by employees readily accessible to and useable by individuals with disabilities; and . . . job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of existing equipment or devices, appropriate adjustment or modifications of examinations, training materials, or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

*Id.*

204. See 42 U.S.C. § 12111(10) (1994) (defining undue hardship as “an action requiring significant difficulty or expense, when considered in light of the factors . . . [considered to determine] . . . whether an accommodation would impose an undue hardship on a covered entity . . .”). Those considered factors include:

(i) the nature and cost of the accommodation needed under this Act; (ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility; (iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type and location of its facilities; and (iv) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

*Id.*

205. See 42 U.S.C. § 12111(8) (1994) (defining qualified individual); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1108 (9th Cir. 2000) (surveying prior court decisions on what constitutes a “qualified individual” for the purposes of ADA Title I standing).

As an initial consideration, a person must prove that they actually have a “disability,”<sup>206</sup> or an impairment that “substantially limits”<sup>207</sup> their ability to perform “major life activities.”<sup>208</sup> When a plaintiff claims an inability to work as limitation in a “major life activity,” they cannot claim a disability due to the inability to fulfill a targeted, narrow position,<sup>209</sup> but must claim the inability “to work in a broad class of jobs.”<sup>210</sup> Further, a disability must be proved on a case-by-case basis<sup>211</sup> that takes into account any mitigating factors taken by the individual.<sup>212</sup> Those mitigating factors can be conscious decisions,

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206. See 42 U.S.C. § 12102(2) (2000) (defining disabled as “a physical or mental impairment that substantially limits one or more of the major life activities or such individual . . . a record of such impairment . . . [or] being regarded as have such an impairment.”).

207. See *Albertson’s, Inc. v. Kirkingburg*, 527 U.S. 555, 565 (1999) (holding that “substantially limits” does not mean a mere difference or reduction in function). In *Kirkingburg*, a plaintiff who suffered from a vision impairment was not “substantially limited” in major life function because his sight was limited to one eye. See *id.* at 564.

208. See, e.g., 42 U.S.C. § 12102(2) (defining disability); *Bragdon v. Abbott*, 524 U.S. 624, 638 (1998) (requiring that “major life activities” be construed in compliance with Rehabilitation Act regulations, 45 C.F.R. § 84.3(j)(2)(ii) (2000), which provides a representative list, including “functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.”).

209. See 29 C.F.R. 1630.2(j)(3)(i). Defining substantially limits ability to work as: [S]ignificantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills and abilities. The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working.

*Id.*

210. See *Sutton*, 527 U.S. at 491 (finding that plaintiffs who were unable to meet vision requirements for international commercial pilot position did not qualify as having “substantial impairments” because there were many other similar positions for which plaintiffs were qualified).

211. See *Kirkingburg*, 527 U.S. at 567 (citing ADA statutory language in determining that although a truck driver with monocular vision may “ordinarily” meet the definition of disability, it is the driver’s burden to prove the extent of his limitations in the “terms of his own experience”); accord *Bragdon*, 524 U.S. at 641 (noting that “[i]n the end, the disability does not turn on personal choice,” but “[w]hen significant limitations result from the impairment, the definition is met even if the difficulties are insurmountable.”); see also 42 U.S.C. § 12102(2) (defining disability in terms of the impact of an impairment); *Sutton*, 527 U.S. at 483 (stating that “[t]he determination of whether an individual has a disability is not necessarily based on the name or diagnosis of the impairment the person has, but rather on the effect of that impairment on the life of the individual.”).

212. See *Sutton*, 527 U.S. at 481 (holding that the use of eyeglasses to correct vision to “20/20 or better” effectively eliminates a person’s “disability” when severe myopia is the basis for the ADA claim).

A person whose physical or mental impairment is corrected by medication or other measures does not have an impairment that presently “substantially limits” a major life activity. To be sure, a person whose physical or mental impairment is corrected by mitigating measures still has an impairment, but if the impairment is corrected it does not “substantially limit” a major life activity. *Id.* at 482-83.

such as wearing eyeglasses to correct impaired vision,<sup>213</sup> or can be subconscious reactions, such as an internal physiological alteration in one eye to compensate for deficiencies in the other.<sup>214</sup>

Second, the plaintiff must be qualified to perform “essential functions”<sup>215</sup> of the position with or without reasonable accommodation.<sup>216</sup> As noted earlier, several circuits have concluded that claims of total disability or the inability to perform a position regardless of accommodation, presumptively precludes an ADA cause of action under Title I.<sup>217</sup> Furthermore, being “qualified” is determined relative to the essential functions of the job.<sup>218</sup> Court decisions provide numerous examples of functions considered essential to certain positions, from general requirements, such as regularly attending work<sup>219</sup> or reporting on time,<sup>220</sup> to the specific,

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213. *See id.*

214. *See Kirkingburg*, 527 U.S. at 556 (stating that “[m]itigating measures . . . must be taken into account in judging whether the individual has a disability . . . whether the measures taken are with artificial aids, like medications and devices, or with the body’s own systems.”).

215. *See* 42 U.S.C. § 12111(8) (allowing the employer typically to determine what duties, if any, are “essential” to a given position).

216. *See* 42 U.S.C. § 12111(9) (defining reasonable accommodation); *see also supra* Part IV.C (explaining in detail the reasonable accommodation analysis).

217. *See* *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1108 (9th Cir. 2000) (holding that employees have standing under the ADA if they are potentially capable of satisfying the employment description).

218. *See* 29 C.F.R. § 1630.2(n)(1) (2000) (defining “essential function” as the fundamental activities of a particular job which an individual holds or is seeking); *see also* 29 C.F.R. § 1630.2(n)(2)(i)-(iii) (2000) (suggesting three factors which may be considered in the “essential function” determination—(1) does the position exist in order to perform a single function; (2) is the number of employees who can do the job limited; and (3) is the job highly specialized, such that the employee was hired for their specific abilities/expertise); 29 C.F.R. § 1630.2(n)(3) (2000) (providing a list of evidence generally considered to imply essential function).

Evidence of whether a particular function is essential includes, but is not limited to: (1) the employer’s judgment as to which functions are essential; (2) written job descriptions prepared before advertising or interviewing applicants for the job; (3) the amount of time spent on the job performing the function; (4) the consequences of not requiring the incumbent to perform the function; (5) the terms of a collective bargaining agreement; (6) the work experience of past incumbents in the job; and/or (7) the current work experience of incumbents in similar jobs.

*See id.*

219. *See* *Horton v. Bd. of Trs. of Cmty. College Dist. No. 508*, No. 95-C-2346, 1996 U.S. Dist. LEXIS 6879, \*13 (N.D. Ill. 1996), *aff’d*, 1997 U.S. App. Lexis 2470 (7th Cir. 1997) (unpublished opinion) (asserting that “coming to work on a regular basis” is a necessary qualification for a job, the *Horton* court found that five years continuous absence from a position was sufficient indication that plaintiff was not a “qualified individual” for ADA purposes); *accord* *Teahan v. Metro-N. Commuter R.R.*, 80 F.3d 50, 54 (2d Cir. 1996) (holding that the link between an employee’s purported alcohol and drug-related disability and his excessive absenteeism was sufficient to prove neither standing under Title I nor that his dismissal was motivated “solely for the reason of his handicap”); *Rogers v. Int’l Marine Terminals*, 87 F.3d 755, 757 (5th Cir. 1996) (asserting that an employer was not obligated under the ADA to

such as the requirement to meet sales quotas<sup>221</sup> or the ability to unload a truck.<sup>222</sup>

### C. Reasonable Accommodation

Once an individual establishes that they are a “qualified individual” for ADA purposes, the “reasonable accommodation” analysis takes place.<sup>223</sup> Reasonable accommodations are steps taken by an employer to permit the disabled individual to perform a job’s essential functions or to “enjoy the same benefits and privileges of employment as non-disabled individuals.”<sup>224</sup> In order to invoke the reasonable accommodation analysis, an employee must: (1) request

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accommodate an employee’s alleged ankle injury/disability by providing an indefinite leave of absence where employee had numerous previous absences for other reasons); *Kinkead v. Southwestern Bell Tel. Co.*, 49 F.3d 454, 456 (8th Cir. 1995) (deciding that an employee’s fifty percent absenteeism rate pre-dating her claim of disability was sufficient nondiscriminatory reason to terminate her employment); *Tydnull v. Nat’l Educ. Ctrs.*, 31 F.3d 209, 213 (4th Cir. 1994) (reasoning that a business college instructor who could not meet the minimum attendance requirements of the job at issue could not be considered a qualified individual protected by the ADA); *Lewis v. Zilog*, 908 F. Supp. 931, 946 (N.D. Ga. 1995), *aff’d*, 87 F.3d 1331 (11th Cir. 1996) (maintaining that the failure to return to work after being granted two sick leave periods due to “stress” meant that the employee could not perform the job’s essential functions); *Vorhies v. Pioneer Mfg. Co.*, 906 F. Supp. 578, 581 (D. Colo. 1995) (holding that regular attendance of a job is an essential function, such that an employee with a back injury was not covered by the ADA where the accommodation requested, a light duty position, did not exist).

220. See *Johnson v. Children’s Hosp.*, No. Civ.A 94-5698, 1995 U.S. Dist. LEXIS 7743, at \*4-5 (E.D. Pa. 1995), *aff’d*, 79 F.3d 1138 (3d Cir. 1996) (unpublished opinion) (finding that excessive tardiness and absenteeism attributable to sickle-cell anemia rendered the plaintiff unable to be relied upon as a radiologist, and therefore not a protected party under the ADA); *accord Kotlowski v. Eastman Kodak Co.*, 922 F. Supp. 790, 798 (W.D.N.Y. 1996) (holding that despite finding that an employee was disabled due to depression for purposes of the ADA, she was otherwise not qualified for a clerical position due to excessive tardiness and absence).

221. See *Sweet v. Elec. Data Sys.*, No. 95-Civ.-1987 (MBM), 1996 U.S. Dist. LEXIS 5544, at \*7 (S.D.N.Y. 1996) (finding that the plaintiff’s failure to meet sales quotas was the most significant reason for his dismissal, not his difficulty in reading due to an eye accident).

222. See *Munoz v. H&M Wholesale*, 926 F. Supp. 596, 608 (S.D. Tex. 1996) (denying the application of Title I to a delivery truck driver who was required, as part of his position, to routinely unload barrels of petroleum for customers).

223. See *supra* Part IV.B (discussing of “qualified individual” as an initial determination of standing under ADA).

224. See 42 U.S.C. § 12111(9) (1994), *supra* note 203 (defining “[r]easonable accommodation”).

[M]aking existing facilities used by employees readily accessible to and useable by individuals with disabilities; and . . . job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of existing equipment or devices, appropriate adjustment or modifications of examinations, training materials, or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

*Id.*

an accommodation;<sup>225</sup> and (2) demonstrate how the accommodation will assist the employee to perform the essential functions of the position.<sup>226</sup> Like the determination of disability, reasonableness of an accommodation is determined on a case-by-case basis,<sup>227</sup> involving a specific factual inquiry.<sup>228</sup> The employee bears the initial burden of demonstrating the “reasonableness” of the accommodation sought,<sup>229</sup> which typically includes a common sense balancing<sup>230</sup> of the proposed accommodation’s effectiveness and the proportional cost to the employer.<sup>231</sup>

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225. See *Vorhies*, 906 F. Supp. at 581-82 (finding against an employee who failed to request an accommodation for a back problem); accord *Voytek v. Univ. of Cal.*, No. C-92-3465EFL, 1994 U.S. Dist. LEXIS 12453 (N.D. Cal. 1994), *aff’d mem.*, 77 F.3d 491 (9th Cir. 1996) (unpublished opinion) (holding that an employer is not required to accommodate for an unknown disability).

226. See *Fussell v. Ga. Ports Auth.*, 906 F. Supp. 1561, 1573 (S.D. Ga. 1995) (finding against a police officer whose tremor prevented him from passing a firearms test because the officer could not identify a suitable accommodation).

227. See *Bragdon v. Abbott*, 524 U.S. 624, 638-39 (1998) (noting that “the ADA must be construed to be consistent with regulations issued to implement the Rehabilitation Act, which does not enunciate a general principal for determining what is and what is not a major life activity . . . [but] instead provide[s] a representative list, defining the term to include ‘functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.’”).

228. See *Wernick v. Fed. Reserve Bank of New York*, 91 F.3d 379, 385 (2d Cir. 1996) (holding that whether an accommodation for a back injury is reasonable is dependent on an examination of the relevant facts of the situation at issue); see also 29 C.F.R. § 1630.9 (2000) (containing regulations on reasonable accommodation which parallel the statutory language).

229. See *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1108 (9th Cir. 2000) (stating that employees bear the burden of demonstrating that they are qualified individuals “who, with or without reasonable accommodations can perform the essential functions of [the] job.”).

230. See *Lyons v. Legal Aid Soc’y*, 68 F.3d 1512, 1517 (2d Cir. 1995) (remanding for consideration of the question of whether purchasing a parking space close to work is a reasonable accommodation for an employee suffering serious injuries and ongoing disability from being struck by an automobile). Factors to be weighed in this analysis include the employer’s geographic location, the availability of such open spaces, the employer’s financial status, etc. See *id.* at 1516; accord *Bryant v. Better Bus. Bureau*, 923 F. Supp. 720, 737 (D. Md. 1996) (citing the EEOC’s Interpretive Guidelines in assessing the “undue hardship” question). These guidelines provide that:

[Undue hardship] is a multi-faceted, fact-intensive inquiry requiring consideration of: (1) financial cost; (2) additional administrative burden implementation; (3) complexity of implementation; and, (4) any negative impact an accommodation may have on the operation of an employer’s business, including the accommodation’s effect on its work force.

*Id.* at 737.

231. See *Vande Zande v. Wis. Dep’t of Admin.*, 44 F.3d 538, 543 (7th Cir. 1995) (allowing the employer an opportunity to prove that the costs of the accommodation are excessive in relation to either the benefits derived therefrom or to the employer’s financial survival and health).

Court decisions provide examples of accommodations found to be both reasonable and unreasonable.<sup>232</sup> Examples of unreasonable requests are: allowing an employee with bi-polar disorder to walk away from supervisors when they caused her stress;<sup>233</sup> requiring an employee to obtain counseling and treatment;<sup>234</sup> or accommodating an employee in a manner that results in harder work and longer hours for other employees.<sup>235</sup> Conversely, examples of measures constituting “reasonable accommodation” include: construction of a special platform to improve the angle at which security personnel viewed monitors;<sup>236</sup> the acquisition of ergonomic furniture;<sup>237</sup> the provision of a chair;<sup>238</sup> and the relocation of employee with HIV-aggravated allergies to a new, mold free facility.<sup>239</sup>

#### D. *Undue Hardship*

Measures constituting a reasonable accommodation are, however, significantly limited by the requirement that such measures must not

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232. See *infra* notes 233-239.

233. See *Reed v. Lepage Bakeries, Inc.*, 102 F. Supp. 2d 33, 38 (D. Me. 2000) (finding that an employee with bi-polar disorder had failed to demonstrate that allowing her to walk away from supervisors in stressful situations was either reasonable or plausible).

234. See *Roberts v. County of Fairfax*, 937 F. Supp. 541, 549 (E.D. Va. 1996) (refusing an employee’s argument that requiring him to attend counseling after demotion for poor performance was a reasonable accommodation, even though regular attendance at counseling was recommended by the employee’s physicians).

235. See *Henderson v. N.Y. Life, Inc.*, 991 F. Supp. 527, 540-41 (N.D. Tex. 1997) (asserting that a request for a part-time schedule or an at-home position to accommodate hypersensitivity to allergies would result in more work for other employees, would deprive New York Life (“NYL”) from effective supervision of employee’s claims processing activity, and would therefore not be reasonable) (citing *Turco v. Hoechst Celanese Chem. Group*, 101 F.3d 1090, 1094 (5th Cir. 1996), *reh’g denied*, 108 F.3d 355 (5th Cir. 1997), and *Munoz v. H&M Wholesale*, 926 F. Supp. 506, 607-08 (S.D. Tex. 1996)).

236. See *Stewart v. Brown County*, 86 F.3d 107, 112 (7th Cir. 1996) (finding that the plaintiff’s employer had made numerous accommodations in addition to constructing a platform, including lowering security monitors and putting blinds on the windows to reduce glare).

237. See *id.* at 109-10 (finding that the purchase of an ergonomic chair at the recommendation of the plaintiff’s chiropractor, in addition to other minor adjustments of the workplace, was a reasonable accommodation); accord *Wernick v. Fed. Reserve Bank of New York*, 91 F.3d 379, 384 (2d Cir. 1996) (relating to a similar accommodation voluntarily made by an employer for a back problem).

238. See *James v. Frank*, 772 F. Supp. 984, 991 (S.D. Ohio 1991) (finding that the delay in obtaining a straight-backed chair accommodating an employee-amputee was unjustified and unreasonable).

239. See *EEOC v. Newport News Shipbuilding & Drydock Co.*, 949 F. Supp. 403, 408 (E.D. Va. 1996) (responding to an employee’s claim that his HIV positive status magnified his reaction to allergens, his employer moved him to a different office building that had a separate air conditioning unit for his own office). The court found that this action was a reasonable accommodation. See *id.* at 408.

impose an undue burden on the employer.<sup>240</sup> In determining whether a requested accommodation poses an undue hardship, several factors are considered,<sup>241</sup> such as (1) the nature and cost of the accommodation;<sup>242</sup> (2) the size and financial status of the employer;<sup>243</sup> (3) accommodations that are “unduly costly or extensive;”<sup>244</sup> or (4) which fundamentally alter a business’ operations or a programs nature are considered unreasonably burdensome.<sup>245</sup>

Undue hardship is also determined on a case-by-case basis by measuring the impact of accommodations proposed by employees as applicable to individual job duties.<sup>246</sup> Consequently, related court decisions reflect the diversity of the American workplace.<sup>247</sup> For

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240. See 42 U.S.C. § 12111(10) (1994); *supra* note 204 (listing the factors to be considered when determining “undue hardship”).

(i) [T]he nature and cost of the accommodation needed under this Act; (ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility; (iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type and location of its facilities; and (iv) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

*Id.*

241. See 42 U.S.C. § 12111(10)(B) (delineating four categories of factors to be considered when determining the presence of an undue hardship).

242. See 29 C.F.R. § 1630 app. (2000) (describing an undue hardship as measures that are “unduly costly, extensive, substantial, or disruptive, or that would fundamentally alter the nature or operation of the business.”).

243. See *id.* (stating that, in some cases, the financial situation of the employer in its entirety should be considered, but in other circumstances, such analysis would be limited to a specific site or office).

244. See *id.* (explaining that a sight-impaired individual could not require a nightclub to provide bright interior lighting in order to work there because the change would be unduly extensive).

245. See *id.* (explaining that the nightclub scenario in *supra* note 244 would also fundamentally alter the nature of the business); see also HOUSE OF REPRESENTATIVES, AMERICANS WITH DISABILITIES ACT OF 1990, H.R. REP. NO. 101-485, pt. 3, at 4 (1990) (re-articulating the four categories of factors considered when determining “undue hardship” and stating that “[o]nly those accommodations which would require significant difficulty or expense when considered in light of the size, resources and structure of the employer would be considered an undue hardship.”); *Garcia-Ayala v. Lederle Parenterals, Inc.*, 212 F.3d 638, 649 (1st Cir. 2000) (applying these criteria to the accommodations requested by an employee who had periodic and lengthy absences from work attributable to several bouts with breast cancer).

246. See 29 C.F.R. § 1630 pt. 1630.2(p), app. (2000) (reflecting concerns that some accommodations may not take into account the financial realities of a particular employer, or the potential disruptions to the workplace).

247. Compare *Mears v. Gulfstream Aerospace Corp.*, 905 F. Supp. 1075, 1081 (S.D. Ga. 1995) (finding that allowing an employee with an inability to handle stress to remain in a position but prohibiting a supervisor from interacting with her would undermine the effectiveness of management and pose an undue hardship on the

instance, although courts have found that forbidding a supervisor from interacting with an employee with a stress-related disability constitutes an undue hardship,<sup>248</sup> they have found that reassigning disabled police officers to light duty and/or civilian positions outside the police department does not.<sup>249</sup>

*E. The Prima Facie ADA Employment Discrimination Case*

Yet, even when an individual is able to meet the above requirements, an individual will not be automatically qualified to obtain relief under Title I of the ADA. It is not enough to show: (1) that an employee is a qualified individual with a disability;<sup>250</sup> (2) who can perform the essential functions of the position<sup>251</sup> with or without accommodation; and (3) that such accommodation is reasonable<sup>252</sup> and does not impose an undue hardship on the employer.<sup>253</sup> As Title I is designed to prevent and remedy actual discrimination,<sup>254</sup> the employee must also show an adverse employment decision based on their disability.<sup>255</sup>

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employer), *with Davoll v. Webb*, 194 F.3d 1116, 1131 (10th Cir. 1999) (recognizing that, while “reassignment of an employee to a vacant position in a company is one of a range of reasonable accommodations which must be considered . . . reassignment might not always be a reasonable accommodation.”).

248. *See Mears*, 905 F. Supp. at 1081.

249. *See Davoll*, 194 F.3d at 1131 (10th Cir. 1999).

250. *See* discussion *supra* Part IV.B (addressing the conditions for a “qualified individual” under Title I).

251. *See* discussion *supra* Part IV.B (relating “essential functions” to “qualified individual”).

252. *See* discussion *supra* Part IV.C (defining what accommodations could be “reasonable”).

253. *See* discussion *supra* Part IV.D (explaining the concept of “undue hardship” as it relates to employers).

254. *See* EEOC Guidance, *supra* note 168 (providing background on the purpose of the employment provisions in ADA Title I).

255. *See Andrews v. Ohio*, 104 F.3d 803, 808-10 (6th Cir.), *reh'g denied*, No. 95-3447, 1997 U.S. App. LEXIS (6th Cir. Feb. 21, 1997) (setting forth these criteria in regard to a suit by highway patrol officers who claimed weight and fitness standards implemented by Ohio were discriminatory in effect); *accord Turco*, 101 F.3d at 1093 (stating that an employee subject to termination due to repeated procedural and safety lapses at a chemical manufacturing plant had to prove that his termination was attributable to discrimination based on his diabetic condition, not safety or performance concerns); *Katz v. City Metal Co.*, 87 F.3d 26, 32 (1st Cir. 1996) (holding that the extent of plaintiff's disability following a heart attack and surgery was a question that could properly be submitted to the jury, as was the question of whether an employer took negative action against the employee based on this condition); *Aucutt v. Six Flags Over Mid-Am., Inc.*, 85 F.3d 1311, 1316 (8th Cir. 1996) (asserting that once the employer articulates a legitimate, nondiscriminatory reason for terminating the plaintiff, the burden then shifts back to the terminated employee to show that the stated reason(s) are actually a pretext); *Bradley v. Harcourt Brace & Co.*, 104 F.3d 267, 271-72 (9th Cir. 1996) (dismissing a terminated employee's ADA claim because of evidence of her poor performance prior to an accident alleged to have caused her partial disability, and due to her testimony that



For individuals with a mental illness, this final requirement provides a “hook” into the employment-based protections in Title I.<sup>256</sup> An employer’s failure to provide equal mental health coverage for certain individuals,<sup>257</sup> and the repercussions of this failure,<sup>258</sup> can be construed as a violation of Title I’s reasonable accommodation provisions. In essence, the individual employee obtains mental health parity as a necessity of continued gainful employment,<sup>259</sup> forcing the employer to pay for such care.<sup>260</sup> Again, this is not the sweeping change sought by mental health consumers and advocates.<sup>261</sup> This approach does, however: (1) achieve equality in health benefits for the individual worker;<sup>262</sup> (2) establish mental health parity as a viable and reasonable accommodation under Title

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her disability began “when she was terminated”); *Morisky v. Broward County*, 80 F.3d 445, 448 (11th Cir. 1996) (finding against an illiterate plaintiff who claimed that the failure of a test proctor to allow a counselor to read a test aloud to her was discrimination based on her disability because the proctor and another personnel employee had no knowledge of her alleged disability); *Howard v. Navistar Int’l Transp. Corp.*, 904 F. Supp. 922, 928 (E.D. Wis. 1995) (holding that an employee’s tendinitis in his elbow did not constitute a disability for ADA purposes because the tendinitis was not considered to “substantially limit a major life activity,” and that adverse actions taken against him due to his inability to work machine shop tools were not disability-based discrimination); *Henry v. Guest Servs., Inc.*, 902 F. Supp. 245, 252 (D.D.C. 1995) (rejecting the notion that the provision of a cartoon making light of depression was a sufficient adverse employment action to constitute discrimination under the ADA).

256. See discussion *infra* Part IV.F (linking employment-based mental health benefits and Title I).

257. See discussion *infra* Part IV.F (limiting Title I protection to the mentally ill who wish to continue working, but are unable to do so without proper health coverage).

258. See discussion *supra* Part IV.C (explaining how the employer’s obligation to provide “reasonable accommodation” protects employees whose disability somehow impedes their work performance).

259. See EEOC Guidance, *supra* note 168, at pt. 1630, app. (providing: “The ADA is a federal antidiscrimination statute designed to remove barriers which prevent qualified individuals with disabilities from enjoying the same employment opportunities that are available to persons without disabilities.”).

260. See 42 U.S.C. § 12111(9) (1994), *supra* note 203 (defining “[r]easonable accommodation”).

[M]aking existing facilities used by employees readily accessible to and useable by individuals with disabilities; and . . . job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of existing equipment or devices, appropriate adjustment or modifications of examinations, training materials, or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.

*Id.*

261. See discussion *supra* Part I.A-C (covering state and federal legislative efforts to broadly prohibit unequal treatment for mental illness, making them illegal for all beneficiaries in employer-sponsored plans); *id.* at Part III (detailing court cases challenging such unequal benefits).

262. See discussion *infra* Part IV.F (explaining how the ADA could be used as a means to supplement mental health benefits under existing health coverage).

I;<sup>263</sup> and (3) prove that individuals with a mental illness can continue to work and lead “normal” lives if given adequate health care.<sup>264</sup> The following section describes a hypothetical real-world scenario adhering to Title I requirements, and demonstrates how the refusal to accommodate an employee’s mental illness through providing mental health parity becomes impermissible discrimination.<sup>265</sup>

*F. Applying Reasonable Accommodation to Unequal Mental Health Benefits*

One of the primary goals of the ADA is to encourage the disabled to work.<sup>266</sup> By framing mental health parity as a “pro-employment” measure,<sup>267</sup> Title I protections can be applied to employees with mental illnesses who receive lesser medical care from their employer as a consequence of the classification of their illness.<sup>268</sup> In the following scenario, the case for mental health parity is less about the injustice and/or impropriety of the mental/physical distinction,<sup>269</sup> but more about the practical effects of unequal health coverage in an every-day, work-based setting.

An employee with manic-depression/bi-polar disorder<sup>270</sup> works for a corporation.<sup>271</sup> The employee, who controls the illness with medication and regular doctor visits, is a productive employee.<sup>272</sup> The

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263. *See id.*

264. *See* Domenici Statement, *supra* note 10, at 3002 (asserting that by providing the mentally ill with the necessary treatment, they can continue to work, and will no longer be imprisoned or pushed to the “margins of society”).

265. *See* discussion *infra* Part IV.F (discussing how the employment-based protections in Title I of the ADA protect an employee with a mental illness who exhausts coverage under the employer-sponsored health plan).

266. *See* 42 U.S.C. § 12112(b)(1) (1994) (banning job discrimination against disabled employees); *see also* H.R. REP. NO. 101-485, *supra* note 245, at 31 (stating that “[t]he underlying premise of [Title I] is that persons with disabilities should not be excluded from job opportunities”).

267. *See* discussion *infra* Part IV.F (connecting the provision of parity benefits to an employee’s desire to continue working).

268. *See* Bee & Gibson, *supra* note 6 (detailing common inequalities in health care coverage between physical and mental illnesses).

269. *See* Hyman Testimony, *supra* note 36 (describing medical evidence that demonstrated many mental illnesses are attributable to physiological conditions in the brain, making the physical/mental distinction invalid).

270. *See* 42 U.S.C. § 12102(2) (2000) (defining disability as “a physical or mental impairment that substantially limits one or more of the major life activities or such individual . . . a record of such impairment . . . [or] being regarded as have such an impairment.”); *see also* Sutton v. United Airlines, 527 U.S. 471, 482 (1999) (“The Act defines a ‘disability’ as ‘a physical or mental impairment that *substantially limits* one or more of the major life activities’ of the individual.”) (emphasis in original).

271. *See* 42 U.S.C. § 12111(10)(B)(iii) (1994) (including size and overall financial resources of the employer as considerations in determining whether the requested accommodation is “reasonable”).

272. *See* Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1108 (9th Cir. 2000) (holding in concert with six other circuits that a “qualified individual” must be able to perform the “essential functions” of the position to have standing under the

employee receives health care benefits through an employer-sponsored health plan,<sup>273</sup> which caps annual and lifetime expenditures for mental illness at a certain amount,<sup>274</sup> but does not cap expenditures for physical illness.<sup>275</sup> The employee exhausts either yearly coverage or aggregate lifetime benefits under the plan.<sup>276</sup> The employee notifies both the boss and the human resources department of the illness<sup>277</sup> and the exhausted health benefits situation, and requests assistance in purchasing a supplemental plan,<sup>278</sup> which would provide benefits in parity with those provided for physical illness.<sup>279</sup> The company refuses. Over the next few months, the employee's illness worsens without proper medication or treatment, which interferes with job performance, such as interacting constructively with fellow employees and supervisors,<sup>280</sup> and completing required tasks in a timely manner.<sup>281</sup> As a result of this diminished performance, the employee is fired.<sup>282</sup> The employee brings suit under Title I of the ADA on the basis of this dismissal. The complaint states that: (1) the company's refusal to assist with the purchase the extended benefit was a refusal to make a "reasonable accommodation;"<sup>283</sup> (2) that this failure exacerbated the mental

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ADA).

273. See Bee & Gibson, *supra* note 6 (indicating that almost all employers who offer health insurance under employer-sponsored health plans include some mental health care benefits).

274. See *id.* (reporting that the median lifetime limit for mental health care spending in an employee-sponsored health plan is \$40,000).

275. See *id.* (observing that health benefits for "physical" ailments typically provide far more money for treatment).

276. See Libertoff Testimony, *supra* note 1, at 1 (providing an example of an individual confronting such limits).

277. See *Vorhies v. Pioneer Mfg. Co.*, 906 F. Supp. 578, 581-82 (D. Colo. 1995) (requiring a person with a disability to notify superiors of such disability before being able to pursue a claim that they failed to accommodate it).

278. See *id.* (requiring that an employee requesting an accommodation must demonstrate that it is workable, reasonable, and effective).

279. See *id.*

280. See *Reed v. Lepage Bakeries, Inc.*, 102 F. Supp. 2d 33, 38 (D. Me. 2000) (concerning an employee who could not constructively interact with other employees and supervisors).

281. See *Horton v. Bd. of Trs. of Cmty. Coll. Dist. No. 508*, No. 95-C-2346, 1996 U.S. Dist. LEXIS 6879 (N.D. Ill. 1996), *aff'd*, 1997 U.S. App. Lexis 2470 (7th Cir. 1997); *accord* *Teahan v. Metro-N. Commuter R.R.*, 80 F.3d 50, 54 (2d Cir. 1996); *Rogers v. Int'l Marine Terminals*, 87 F.3d 755, 757 (5th Cir. 1996); *Kinhead v. Southwestern Bell Tel. Co.*, 49 F.3d 454, 456 (8th Cir. 1995); *Tydnall v. Nat'l Educ. Ctrs.*, 31 F.3d 209, 213 (4th Cir. 1994); *Lewis v. Zilog, Inc.*, 908 F. Supp. 931, 946 (N.D. Ga. 1995); *Vorhies*, 906 F. Supp. at 581.

282. See *Bradley v. Harcourt Brace & Co.*, 104 F.3d 267, 271-72 (9th Cir. 1996) (dismissing a terminated employee's ADA claim due, in part, to her testimony that her disability began "when she was terminated").

283. See discussion *supra* Part IV.C (covering requirements of "reasonable accommodation"); see also 42 U.S.C. § 12111(9) (1994); *supra* note 203 (defining "[r]easonable accommodation.").

illness, which in turn negatively effect job performance;<sup>284</sup> and (3) therefore the termination was inextricably linked to the illness and the mental disability.<sup>285</sup>

In this hypothetical case, the plaintiff adheres to the “road map” of an ADA Title I claim: (1) a disability limiting major life function (broad “ability to work”);<sup>286</sup> (2) a willingness to perform job duties (is not claiming total disability);<sup>287</sup> (3) the employee notified the employer of the disability and requested an accommodation (the request for supplemental coverage);<sup>288</sup> (4) the employer refused the accommodation;<sup>289</sup> and (5) consequently was subject to an adverse employment action due to the disability (employee was fired).<sup>290</sup>

Although the ADA provides several affirmative defenses to “reasonable accommodation” requests,<sup>291</sup> it does not appear that any of them are applicable in the foregoing scenario. The employer may claim that the employee’s requested accommodation is unreasonable and poses an undue hardship on the employer.<sup>292</sup> If the employer is

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284. See discussion *supra* Part IV.E (establishing that, for the purposes of a *prima facie* Title I claim, an employee must actually suffer an adverse employment decision based on the disability to qualify for relief).

285. See discussion *supra* Part IV.B (providing examples of when an employer did or did not make a reasonable accommodation for an employee). In situations where the employee could not establish a linkage between his or her disability and termination, courts routinely dismissed charges. See *Kotlowski v. Eastman Kodak Co.*, 922 F. Supp. 790, 800 (W.D.N.Y. 1996) (finding former employee did not rebut employer’s evidence that employee’s performance inadequacies were the real reason for being laid off); *Johnson v. Children’s Hosp.*, No. Civ.A 94-5698, 1995 WL 338497, at \*2 (E.D. Pa. 1995).

286. See *Sutton*, 527 U.S. at 491 (requiring, “at a minimum,” that the plaintiff “allege [an inability] to work in a broad class of jobs”).

287. See 42 U.S.C. § 12111(8) (1994) (defining qualified individual); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1108 (9th Cir. 2000) (surveying prior court decisions on what constitutes a “qualified individual” for the purposes of ADA Title I standing).

288. See *Vorhies v. Pioneer Mfg. Co.*, 906 F. Supp. 578, 581-82 (D. Colo. 1995) (finding against an employee who failed to request an accommodation for a back problem); accord *Voytek v. Univ. of Cal.*, No. C-92-3465EFL, 1994 U.S. Dist. LEXIS 12453 (N.D. Cal. 1994), *aff’d mem.* 77 F.3d 491 (9th Cir. 1996) (unpublished opinion) (holding that an employer is not required to accommodate for an unknown disability).

289. Compare *Stewart v. Brown County*, 86 F.3d 107, 112 (7th Cir. 1996) (finding that the county made reasonable accommodations, and that the statute does not require employers to find a “perfect cure for the problem”), with *James v. Frank*, 772 F. Supp. 984 (S.D. Ohio 1991) (providing injunctive relief because of the postal service’s “inexcusable” practice of failing to accommodate employee’s physical handicap).

290. See *Vorhies*, 906 F. Supp at 581-82; see also discussion *supra* Part IV.E (providing the requirement of an adverse employment decision for a Title I claim).

291. See discussion *infra* Part IV.F (detailing potential employer defenses, including “undue burden” and the insurer “safe harbor”).

292. See discussion *supra* Part IV.D (including the factors to be considered when determining whether an accommodation poses an undue hardship).

small or has limited financial resources,<sup>293</sup> this financial argument may be persuasive.<sup>294</sup> However, in cases where the employer is not so situated, size, profitability and other “balance sheet” factors would work to the employee’s advantage when determining the employer’s relative burden.<sup>295</sup> Similarly, because the accommodation requested is primarily external to the actual workplace (i.e. more comprehensive health coverage to be accessed elsewhere), the accommodation would not be intrusive on the actual day-to-day functioning of the business,<sup>296</sup> and would neither create more work for others<sup>297</sup> nor impinge on management’s oversight of the employee.<sup>298</sup> Subsequently, the requested accommodation does not appear on its face unreasonable or unduly burdensome under the reasoning of prior courts.<sup>299</sup>

Additionally, the employer may assert the ADA’s “safe harbor” defense.<sup>300</sup> The “safe harbor” provision allows insurers to classify and

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293. See H.R. REP. NO. 101-485, *supra* note 245, at 40-42 (explaining the Judiciary Committee’s intent not to jeopardize the success of viability of enterprises with limited resources).

294. See *id.* at 39-42 (stating that “[o]nly those accommodations which would require significant difficulty or expense when considered in light of the size, resources and structure of the employer would be considered an undue hardship.”).

295. See *Lyons v. Legal Aid Soc’y*, 68 F.3d 1512, 1516-17 (2d Cir. 1995) (listing what factors need to be examined in determining employer’s burden). The court stated that:

The question of whether it is reasonable to require an employer to provide [an accommodation] may well be susceptible to different answers . . . [requiring] ‘common-sense balancing of the costs and benefits’ to both the employer and the employee . . . [and] an accommodation may not be considered unreasonable merely because it requires the employer to ‘assume more than a *de minimis* cost’

*Id.* (quoting *Borkowski v. Valley Cent. Sch. Dist.*, 63 F.3d 131, 138 n.3, 140 (2d Cir. 1995)).

296. See *Henderson v. N.Y. Life, Inc.*, 991 F. Supp. 527, 540-41 (N.D. Tex. 1997) (finding that allowing an employee to work at home would deprive NYL of supervision and would be disruptive to other employees); see also 42 U.S.C. § 12111(10) (1994) (including “the impact . . . of such accommodation upon the operation of the facility” as a factor to consider when determining “undue hardship”).

297. See *id.* (stating that the ADA does not require any accommodation that would require other employees to work harder or for longer hours).

298. See *id.* (holding that a valid reason for denying any accommodation was that it deprived NYL of the ability to supervise employee’s work).

299. See discussion *supra* Part IV.D (explaining the application of the “undue hardship” defense).

300. See 42 U.S.C. § 12201(c) (1994 & Supp. IV 1998).

[Titles I through III] shall not be construed to prohibit or restrict—(1) an insurer . . . or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks classifying risks, or administering such risks that

adjust risks according to traditional industry practices.<sup>301</sup> Presumably, the employer could claim that the differential coverage for mental illness was a valid and allowed distinction based on actuarial data and common risk adjustment assumptions.<sup>302</sup> In a reasonable accommodation claim, however, the employee is not seeking a blanket condemnation of the underlying benefit structure, but is merely seeking an individualized remedy to its effect. Consequently, the employee avoids arguments about the validity of the actuarial and risk adjustment assumptions contained within the plan, thereby removing the “safe harbor” provision from the calculus of the requested accommodation.<sup>303</sup>

In sum, the employee in the foregoing hypothetical framed the issue of unequal coverage for mental illness as impairing his or her continuing ability and desire to work.<sup>304</sup> The employee thus finds a “back door” into Title I of the ADA for mental health parity, avoiding both the statutory defenses,<sup>305</sup> and the courts’ reluctance to declare unequal coverage discriminatory under the ADA.<sup>306</sup>

#### CONCLUSION

Though progress toward equal treatment for Americans with a mental illness has been difficult,<sup>307</sup> opportunities to achieve parity do

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are based on or not inconsistent with State law. . . .

*Id.*

301. See *Weyer*, 198 F.3d at 1116 (stating that “[b]y putting an insurance company ‘safe harbor’ in the Act, Congress gained such freedom of choice for policy purchasers and efficiencies for insurers as might accrue if insurance companies were free to decide whether to cover and to what extent to cover various disabilities.”).

302. See *id.* (stating the rationale for risk adjustment for mental illnesses).

The coverage of mental disability and physical disability involves different risks with different hazards or exposure . . . [we are advised] that research shows that policies that do not place a limit on the duration of benefits [for mental illness] receive nearly double the percentage of mental disorder claims as policies with such limits.

*Id.*

303. See 29 C.F.R. app. § 1630.16(f) (2000) (requiring that decisions not based on risk classifications must be made in conformity with Title I of the ADA); see also *Esfahani v. Med. Coll.*, 919 F. Supp. 832, 836 (E.D. Pa. 1996) (holding that although diagnosis-based distinctions in the administration of long-term disability plans are permissible under the ADA, distinctions providing lesser benefits for mental illness than for physical illness do not fall within the protection of the law if they are “arbitrary, discriminatory or without scientific basis”).

304. See discussion *supra* Part IV.A (linking the protections in Title I of the ADA to employment situations).

305. See discussion *supra* Part IV.D (providing defense of “undue hardship”); see also 42 U.S.C. § 12201(c) (1994) (containing the statutory “safe harbor” defense).

306. See discussion *supra* Part III (surveying court decisions declining to require mental health parity under the ADA).

307. See discussion *supra* Parts I and III (explaining legislative and legal impediments to equal health care coverage).

exist.<sup>308</sup> Legislatively, one could certainly view the sunset date of the MHPA<sup>309</sup> as a backward step, but it could also be viewed as a chance to again galvanize the mental health community and draw national attention to the matter.<sup>310</sup> Since passage of the 1996 MHPA,<sup>311</sup> more information on the cost of “parity coverage” has been gathered,<sup>312</sup> helping substantiate claims that such coverage is not prohibitively expensive.<sup>313</sup> However, changes in benefit structures in the wake of the 1996 MHPA<sup>314</sup> should not be discounted. Rather, such information could effectively be used in advocating for the passage of S. 543 in the 107th Congress.<sup>315</sup> Due to Congress’ reluctance to pass a “wide open” parity provision,<sup>316</sup> and real concerns about the unintended consequences of parity in the voluntary health care market,<sup>317</sup> a more controlled, targeted approach to parity should be the goal.<sup>318</sup> This approach is embodied in S. 543,<sup>319</sup> which both

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308. *See id.* (advocating for separate, but complimentary legislative and litigation-based approaches to achieving equal treatment for mental illness).

309. *See* 29 U.S.C. § 1185a(f) (1994 & Supp. IV 1998) (“This section shall not apply to benefits for services furnished on or after September 30, 2001.”).

310. *See* 147 CONG. REC. S2393 (daily ed. Mar. 15, 2001) (statement of Sen. Domenici) (“The introduction of our Bill marks a historic opportunity for us to take the next step towards mental health parity. The timing of our Bill is even more important because the landmark Mental Health Parity Act of 1996 will sunset on September 30 of this year.”).

311. *See* 29 U.S.C. § 1185a (1994 & Supp. IV 1998).

312. *See* GAO Letter Report, *supra* note 14, at 16 (finding that only three percent of surveyed employers reported increases in claims costs pursuant to their compliance with the 1996 MHPA).

313. *See id.*

314. *See id.* at 16 (stating that employers implementing the requirements of the 1996 MHPA also responded by “tightening other design features” in order to control costs and utilization).

315. *See* 147 CONG. REC. S2395 (daily ed. Mar. 15, 2001) (statement of Sen. Wellstone).

Since the Mental Health Parity Act became law, we have seen that the costs have remained low and manageable, but, unfortunately, we have also seen that employers and insurance companies have taken advantage of the gaps that remain in coverage for mental illness. Patients have faced increases in copayment and deduction costs, more problems in gaining access to care, fewer approvals for hospital stays and outpatient days, and refusals to cover care. The suffering of people with mental illness has grown, and the time to end this discrimination is now.

*Id.*

316. *See* Dole Statement, *supra* note 98 (remarking “the [Domenici/Wellstone Amendment is] a very, very expensive provision, and it’s going to cause all kinds of problems”).

317. *See* Rosen Testimony, *supra* note 100 (estimating that each one percent increase in insurance costs results in 200,000 to 300,000 fewer covered lives).

318. *See* discussion *supra* Part II.B (demonstrating that parity coverage can be introduced, without an upward spike in costs, if done so in conjunction with benefit and utilization management).

319. *See* discussion *supra* Part II.A-D.

requires full parity for medically-necessary services<sup>320</sup> and allows insurers some flexibility in benefit design<sup>321</sup> to allay their fears of increased costs and utilization.<sup>322</sup>

Federal courts have shown the same reluctance to implement parity when considering challenges to unequal health care coverage brought under the ADA.<sup>323</sup> In light of such decisions, it is time to consider a less-sweeping, individualized approach.<sup>324</sup> Specifically, future court challenges to unequal coverage for mental illness should focus on how such coverage affects an individual's ability to maintain gainful employment.<sup>325</sup> Under this approach, mental health parity becomes a "reasonable accommodation" for an individual with a mental illness, requiring the employer to provide parity in order to comply with ADA Title I protections. While this approach lacks the broad-based, remedial effect of declaring unequal benefits presumptively discriminatory, it provides real, necessary relief for individuals suffering from a mental illness.<sup>326</sup>

Whether combining these strategies or pursuing them separately, the goals should be to protect those most in need of treatment, and to build critical mass behind the push for mental health parity.<sup>327</sup> Although the change sought in either case may not be the "seismic" shift many mental health advocates and consumers desire, such changes: (1) provide real relief to individuals with a mental illness;

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320. See *The Mental Health Equitable Treatment Act of 2001*, S. 543, 107th Cong. § 2705(e)(3) (2001) (providing parity for services "included as part of an authorized treatment plan that is in accordance with standard protocols and such services meet applicable medical necessity criteria").

321. See *id.* § 2705 (providing that "coverage shall not impose any treatment limitations of financial requirements with respect to the coverage of benefits for mental illness unless comparable treatment limitations or financial requirements are imposed on medical and surgical benefits").

322. See discussion *supra* Part I.D (referencing opposition to parity based on fear of escalating costs).

323. See discussion *supra* Part III (surveying numerous judicial decisions declining to extend ADA protections to unequal mental health coverage).

324. See discussion *supra* Part IV.F (establishing the parameters of an individualized Title I approach).

325. See *id.*

326. See *id.* (asserting that this individualized parity coverage would provide tangible benefit to an individuals who exhaust their non-parity, employer-sponsored coverage).

327. See 147 CONG. REC. S2395 (daily ed. Mar. 15, 2001) (statement of Sen. Kennedy).

As we have learned more about the brain and the way it works, we have developed promising treatments that can significantly improve the health of individuals with mental illness and help them lead productive lives. Success rates for treating mental illness are now as high as 80 percent. Without strong parity legislation, however, these effective treatments will remain elusive for the millions of individuals who need them.

*Id.*



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(2) continue to provide important cost data and societal experience, helping further discredit current, well-established resistance to mental health parity; and (3) move the law closer to the overall goal of complete and equal treatment for all Americans suffering from a mental illness.