

2005

## Mental Health Parity for Children and Adolescents: How Private Insurance Discrimination and ERISA Have Kept American Youth From Getting the Treatment They Need

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### Recommended Citation

Boison, Elizabeth S. "Mental Health Parity for Children and Adolescents: How Private Insurance Discrimination and ERISA Have Kept American Youth From Getting the Treatment They Need." *American University Journal of Gender, Social Policy & the Law*. 13, no. 1 (2005): 186-218.

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# MENTAL HEALTH PARITY FOR CHILDREN AND ADOLESCENTS:

## HOW PRIVATE INSURANCE DISCRIMINATION AND ERISA HAVE KEPT AMERICAN YOUTH FROM GETTING THE TREATMENT THEY NEED

ELIZABETH S. BOISON\*

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## INTRODUCTION

Three years ago, Timothy O'Clair hung himself in his bedroom seven weeks before his thirteenth birthday.<sup>1</sup> Over the years, he had received sporadic treatment for depression, attention deficit hyperactivity disorder ("ADHD"), and oppositional defiance disorder ("ODD").<sup>2</sup> Even though his parents were fortunate enough to have private insurance that covered outpatient mental healthcare, a lack of parity between Timothy's mental and medical benefits kept his family from being able to afford the residential mental health treatment he so desperately needed.<sup>3</sup>

The limitations on Timothy's treatment forced the O'Clairs to go as far as relinquishing custody of Timothy at one point so that he could seek treatment at the state's expense.<sup>4</sup> Clearly, these interruptions and setbacks rendered Timothy's care inadequate.<sup>5</sup> If parity legislation<sup>6</sup> outlawing this kind of insurance discrimination had been in place during Timothy's lifetime, he might have received the appropriate inpatient care that would have prevented his death.<sup>7</sup> His suicide, representative of the plight of other mentally ill children and adolescents who cannot get the care they need, led legislators in his

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1. See Jane Kwiatkowski, *Seeking Help from "Timothy's Law,"* BUFFALO NEWS, May 20, 2003, at C1 (explaining that Timothy's death sparked a movement in the New York legislature to address insurance discrimination).

2. See *Timothy's Story*, at <http://www.timothyslaw.org/story.htm> (last visited Feb. 10, 2005) (describing Timothy's erratic and dangerous behavior, such as throwing rags into his family home's furnace, which developed in the years prior to his suicide).

3. See Kwiatkowski, *supra* note 1, at C1 (reporting that most insurance plans limit mental healthcare to thirty days of inpatient care and twenty outpatient visits per year); *Timothy's Story*, *supra* note 2 (noting that Timothy's family paid ten dollars per medical visit but thirty-five dollars for mental health visits, quickly racking up bills that they could not afford).

4. See *Timothy's Story*, *supra* note 2 (explaining that parents in New York state may place their children in foster care so that Medicaid covers the child's mental healthcare); see also U.S. GEN. ACCOUNTING OFFICE, CHILD WELFARE AND JUVENILE JUSTICE 4, 5 (2003) [hereinafter GAO REPORT ON CHILD WELFARE] (reporting that parents who voluntarily place their children in custody of the state often do so because their private insurance does not cover the child's necessary mental health treatments). But see *Timothy's Story*, *supra* note 2 (noting that the O'Clairs still had to pay the state \$452 per month while Timothy was under state custody).

5. See *Timothy's Story*, *supra* note 2 (noting that Timothy's treatment, whether inpatient or outpatient, was "limited and sporadic, as insurance coverage and the family budget allowed"). But see *id.* (stating that Timothy received high quality treatment when his insurance company made it available).

6. See Beth Mellen Harrison, *Mental Health Parity*, 39 HARV. J. ON LEGIS. 255, 255 (2002) (defining "parity legislation" as laws requiring health insurance plans to provide the same level of benefits for mental health care as they offer for medical and surgical services).

7. See Kwiatkowski, *supra* note 1, at C1 (quoting Timothy's father as saying, "[H]ad [parity] been implemented years ago, we're sure Timothy would still be here with us").

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state to write a mental health parity bill, "Timothy's Law."<sup>8</sup>

This Comment advocates private insurance parity as a means of addressing the mental health needs of America's youth.<sup>9</sup> While parity advocates should continue to lobby for progress on the state level, federal legislation is also needed in order to compel compliance from all benefit plans, legitimize the momentum parity has already gained in the states,<sup>10</sup> and enable states to realize the mental health parity that their legislatures intended.<sup>11</sup>

Part I of this Comment explains the urgency of meeting the mental health needs of America's children and adolescents.<sup>12</sup> While covering the cost of treating intellectual disabilities in children is an equally important and controversial subset of mental illness, this Comment will instead focus on coverage of Clinical and Personality Disorders (as opposed to Mental Retardation), as defined in the *Diagnostic and Statistical Manual of Mental Disorders IV* ("DSM" or "DSM-IV").<sup>13</sup>

8. See A. 08301/S. 5329, 226th Leg. (N.Y. 2003), available at <http://assembly.state.ny.us/leg/?bn=s5329> (last visited Nov. 15, 2004) (on file with *Journal*). The bill required:

every [insurance] policy delivered or issued in [New York] which provides coverage for medical or hospital care . . . [to] provide coverage for the treatment and diagnosis of mental, nervous[,] or emotional disorders or ailments and those disorders or ailments associated with alcoholism, alcohol abuse, substance abuse, and substance or chemical dependence . . .

*Id.*; see also A. 08301/S. 5329, 227th Leg. (N.Y. 2004) (containing language identical to its predecessor). The bill passed in the Assembly but stalled out in the New York State Senate just as had the 2003 version of Timothy's Law). *Id.*; see also Michael Cooper, *The Most Expensive Budget in the Least Productive Legislative Session*, N.Y. TIMES, Aug. 22, 2004, at A32 (reporting that many called the 2004 session of the New York State Legislature "the least productive [session] in memory").

9. See discussion *infra* Part II (noting that employer-sponsored private insurance is the most prevalent form of coverage in the United States).

10. See Ruth L. Kirschstein, *Insurance Parity for Mental Health: Cost, Access, and Quality, Final Report to Congress by the National Advisory Mental Health Council 8* (2000) (noting that only five states had parity laws prior to passage of the Mental Health Parity Act of 1996 ("MHPA" or "MHPA of 1996"), 29 U.S.C. § 1185a (1999)), available at <http://www.nimh.nih.gov/publicat/nimhparity.pdf> (last visited Feb. 10, 2005). Passage of this federal law substantially influenced the mental parity movement. *Id.*

11. See, e.g., S.B. 534, 1999 Leg., Jan. Sess. (Conn. 1999) (declaring the Connecticut legislature's intent that its parity law "ensur[e] full parity for mental health coverage under insurance and managed care"); Gail A. Jensen & Michael A. Morrissey, HEALTH INS. ASS'N OF AM., MANDATED BENEFIT LAWS AND EMPLOYER-SPONSORED HEALTH INSURANCE, at i (1999) (noting that ERISA prevents a state insurance mandate from impacting approximately fifty-eight to sixty-seven percent of a given state's population), available at <http://membership.hiaa.org/pdfs/jensenrpt.pdf> (last visited Feb. 10, 2005).

12. See generally discussion *infra* Part I (explaining that parity for treatment of mentally ill children and adolescents should be a priority).

13. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., American Psychiatric Publishing, Inc. 1994) (representing the most authoritative source for the diagnosis of mental illness); see also *Bush Offers Initiative To Aid Mentally Ill*, WASH. POST, Jul. 27, 2003, at A4 (reinforcing the notion

Part II explores how Americans currently pay for their mental healthcare and explains how these funding mechanisms leave gaps in coverage.<sup>14</sup> Part III demonstrates that a national parity law would cost less than some fear.<sup>15</sup> Part IV examines the Employment Retirement Security Act of 1974<sup>16</sup> ("ERISA") and how it has created a "regulatory gap" that has frustrated states' commendable efforts to provide for their citizens.<sup>17</sup>

Part V applies current preemption analysis and hypothesizes the results that victims of insurance discrimination, such as the O'Clairs, might expect if they sought legal redress in court for their loss.<sup>18</sup> Part VI explores the possibility of basing a claim for insurance discrimination on the Americans with Disabilities Act ("ADA").<sup>19</sup> Part VII evaluates the potential effectiveness of the Wellstone Act,<sup>20</sup> as well as other federal legislation, and makes recommendations for further reform.<sup>21</sup> Part VIII examines whether continued regulation on the

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that intellectual disabilities are a distinct subset of mental health issues that may be addressed separately from mental illness).

14. See generally discussion *infra* Part II (identifying employer-sponsored health plans as the most common form of healthcare and noting problems regarding coverage, cost, and company discretion to alter available benefits).

15. See discussion *infra* Part III (asserting that such a law would increase insurance premiums by less than one percent).

16. 29 U.S.C. § 1001-1461 (1999).

17. See Gary A. Francesconi, *ERISA Preemption of "Any Willing Provider" Laws—An Essential Step Toward National Health Care Reform*, 73 WASH. U. L.Q. 227, 236 (1995) (observing that ERISA's preemption clause creates a regulatory gap because it overrides state statutes without addressing some of the major issues from the federal level); Keith Nelson, Comment, *Legislative and Judicial Solutions for Mental Health Parity: S. 543, Reasonable Accommodation, and an Individualized Remedy Under Title I of the ADA*, 51 AM. U. L. REV. 91, 100 n.53 (2001) (recognizing that while over forty-three [now forty-six] states and the District of Columbia have parity laws in place, the preemption clause of ERISA has precluded meaningful or consistent application of these laws). But see Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y. REV. 443, 452 (2003) (observing that any regulatory gap has been narrowed by recent decisions such as *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)). *Rush Prudential* enhanced the states' abilities to regulate HMOs and other healthcare vehicles that formerly were the sole domain of the federal government. *Id.* at 402.

18. See generally Kwiatkowski, *supra* note 1 (describing the O'Clair family's story).

19. See Americans with Disabilities Act, 42 U.S.C. § 12101 (1994) (prohibiting workplace discrimination against individuals with disabilities); Nelson, *supra* note 17, at 121 (exploring whether the ADA is a viable basis for challenging the denial of mental health benefits); see also discussion *infra* Part VI (demonstrating why the ADA will not redress a child or teen who was wrongfully denied mental health benefits).

20. See The Wellstone Mental Health Equitable Treatment Act of 2003, S. 486, 108th Cong. (2003) (prohibiting health insurance companies that cover mental health treatment from capping their benefits at a level any lower than they cap medical or surgical coverage).

21. See discussion *infra* Part VII (recommending that Congress pass legislation that would mandate parity for all employee welfare plans, including those that self-fund).

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state level represents the best way to achieve parity and suggests statutory language that states could use in pursuit of this goal.<sup>22</sup>

I. MENTAL HEALTHCARE FOR CHILDREN AND ADOLESCENTS  
SHOULD BE A NATIONAL PRIORITY BECAUSE THE CURRENT SYSTEM HAS  
FAILED TO SERVE AMERICA'S YOUTH

Despite estimates that twelve percent of the population ages nine through seventeen has a diagnosable psychiatric disorder,<sup>23</sup> up to two-thirds of these children have never received treatment.<sup>24</sup> Since the most serious psychiatric disorders, such as schizophrenia, often appear during late adolescence, it is critical that teens have timely access to high quality diagnostic resources.<sup>25</sup> Because most teens are covered by a parent's health plan,<sup>26</sup> private insurance parity is the way to achieve a maximum benefit to society.<sup>27</sup>

The high correlation rate between mental illness and criminal behavior (including illicit substance abuse)<sup>28</sup> is an obvious indicator

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22. See discussion *infra* Part VIII (recommending various strategies states could employ to make their parity laws more effective).

23. See U.S. PUB. HEALTH SERVICES, REPORT OF THE SURGEON GENERAL'S CONFERENCE ON CHILDREN'S MENTAL HEALTH: A NATIONAL ACTION AGENDA, DEP'T OF HEALTH AND HUMAN SERVICES 123 (2000) [hereinafter SURGEON GENERAL'S REPORT] (defining diagnosable psychiatric disorders to include anxiety, mood, disruptive, and substance abuse disorders). But see Dennis E. Cichon, *Developing a Mental Health Code For Minors*, 13 T.M. COOLEY L. REV. 529, 534 (1996) (opining that *DSM-IV* definitions, such as ODD, are so broad and vague that all teens could, at some point, be diagnosed with some sort of mental disorder).

24. Glenn Ruffenach, *Health: Slashes in Mental-Health Benefits Start To Hurt Patients, Medical Officials Say*, WALL ST. J., Mar. 19, 1991, at B1 (noting that in Georgia, only 18,000 of an estimated 90,000 children who need treatment for severe emotional disturbance will receive help from community programs in 1991).

25. See 147 Cong. Rec. S11165, 11174 (daily ed. Oct. 30, 2001) (statement of Sen. Wellstone) (reporting that early treatment of children with mental illness can have a "huge impact on whether they end up in . . . more trouble, then incarceration"); see also Robert McGough, *Screening Program Aims to Prevent Suicides by Teens*, WALL ST. J., Feb. 21, 2003, at B5 (describing an outreach program that attempts to identify teens in need of mental healthcare through confidential, computer-based assessments); Sally Satel & Keith Humphreys, *Mind Games*, WEEKLY STANDARD, Oct. 13, 2003, at 23 (identifying children and adolescents with serious mental illnesses as the parties most likely to benefit from parity legislation).

26. See Press Release, Employee Benefit Research Institute, EBRI Survey Examines Americans' Confidence in the Health Care System (Sept. 9, 1999) (on file with author) [hereinafter EBRI Press Release] (reporting that the majority of Americans receive coverage from a private, employer-sponsored health plan).

27. Satel & Humphreys, *supra* note 25, at 23 (noting that parents' devastation at discovering their child is mentally ill is compounded by the prospect of having to pay for treatment and incurring enormous debt).

28. See, e.g., Jennifer L. Morris, *Criminal Defendants Deemed Incapable To Proceed to Trial: An Evaluation of North Carolina's Statutory Scheme*, 26 CAMPBELL L. REV. 41, 49 (2004); Richard E. Redding, *Why It Is Essential To Teach About Mental Health Issues in Criminal Law (And a Primer on How To Do It)*, 14 WASH. U. J.L. & POL'Y 407, 417-18 (2004).

of the need to treat today's youth in order to avoid bearing the future social costs, which include crime, homelessness, substance abuse,<sup>29</sup> and lost productivity.<sup>30</sup> The price tag on these social costs already exceeds \$113 billion per year in the United States.<sup>31</sup>

The cost borne by society will only increase since the rate of mental illness diagnosis among children and adolescents increases each year.<sup>32</sup> Suicide among youth ages fifteen through twenty-four tripled between 1990 and 2000.<sup>33</sup> Increased environmental stress, induced by such events as the September 11th attacks, put at-risk youth in even greater danger of developing a mental disorder.<sup>34</sup>

In the best-case scenario for most mentally ill children or adolescents, they could receive community-based services on an outpatient basis and be able to reside at home with their families, who would only have to bear a fraction of the cost.<sup>35</sup> Because community-

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29. See U.S. DEPT. OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM 22 (2000) [hereinafter SUBSTANCE ABUSE SERVICE UNDER SCHIP] (reporting that fifteen percent of adolescents with severe emotional disorders are already in need of substance abuse treatment).

30. See 147 Cong. Rec. S11165, 11174 (daily ed. Oct. 30, 2001) (statement of Sen. Wellstone) (stating that the cost of untreated mental illness increases exponentially when other health problems result, leading to emergency room visits and other societal costs); see also THE GLOBAL BURDEN OF DISEASE: A COMPREHENSIVE ASSESSMENT OF MORTALITY AND DISABILITY FROM DISEASES, INJURIES, AND RISK FACTORS IN 1990 AND PROJECTED TO 2020 10 (Christopher L. Murray & Alan D. Lopez eds., 1996) (reporting that depression is the leading cause of disability worldwide); *Talk of the Nation: Mental Health Parity* (NPR radio broadcast, April 30, 2002) (transcript on file with the author) [hereinafter *Talk of the Nation*] (reporting that thirty-five to fifty percent of homeless people would not be homeless had they received mental health treatment during their youth).

31. See NATIONAL MENTAL HEALTH ASS'N, LABOR DAY 2001 REPORT: UNTREATED AND MISTREATED MENTAL ILLNESS AND SUBSTANCE ABUSE COSTS U.S. \$113 BILLION A YEAR, (positing that ninety percent of this \$113 billion cost comes in the form of lost productivity), available at <http://www.nmha.org/pdffdocs/laborday2001.pdf> (last visited Feb. 10, 2005).

32. See SURGEON GENERAL'S REPORT, *supra* note 23, at 428 (acknowledging that improvements in America's capability to identify and diagnose mental illness have developed at a faster pace than America's ability to treat or prevent such illness).

33. See *id.* at 154 (asserting that the suicide rate is a proxy for the mental illness rate since over ninety percent of children and adolescents who commit suicide are mentally ill); see also McGough, *supra* note 25, at B5 (reporting that 1,621 teens committed suicide during 2000).

34. See *Children of September 11: The Need for Mental Health Services: Hearing Before the Committee on Health, Education, Labor, and Pensions*, 107th Cong. 48 (2002) (statement of Christina Hoven, M.D., witness) (testifying that an additional estimated 60,000 New York City schoolchildren have exhibited signs of mental disorders since September 11, 2001, and forewarning that many more children will begin to manifest symptoms of disturbance many years after the tragedy).

35. See Antony B. Klapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 745 (1993) (stating that community-based therapy is more cost-effective and often more beneficial than inpatient care). *But see* Pennhurst St. Sch. & Hosp. v. Halderman, 451 U.S. 1, 31 (1981) (approving inpatient care and finding that states have no affirmative

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based services are not available in all areas, the burden of caring for these children and adolescents on an inpatient basis falls on the taxpayers (i.e., state juvenile delinquency and foster care systems).<sup>36</sup> Often, youth who need mental health services are bounced among the various state agencies, because states are not necessarily equipped to give them the mental healthcare they need, and the states do not know what else to do with them.<sup>37</sup> This lack of community-based treatment has also led to a high rate of unwarranted institutionalization of children who have mild, correctable psychological disorders.<sup>38</sup>

## II. CURRENT MENTAL HEALTHCARE FUNDING MECHANISMS

The current parity debate focuses on requiring private, employer-sponsored health plans to cover mental health treatment.<sup>39</sup> Although many children and adolescents may receive state-funded healthcare through Medicaid or the State Children's Health Insurance Program ("SCHIP"),<sup>40</sup> employer-sponsored welfare plans are the most common

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responsibility to provide appropriate treatment in the "least restrictive" environment); *Timothy's Story*, *supra* note 2 (noting that in Timothy's exceptionally dire case, community-based treatment probably would not have sufficed).

36. See GAO REPORT ON CHILD WELFARE, *supra* note 4, at 17 (reporting that during fiscal year 2001, exasperated parents placed over 9,056 children in child welfare or juvenile justice systems as a final effort to get them the care they needed); see also *Timothy's Story*, *supra* note 2 (noting that Timothy experienced a series of placements at taxpayer expense).

37. See Dennis E. Cichon, *The Ignored Population: Children in the Mental Health System*, 17 T.M. COOLEY L. REV. 9, 12 (2000) (noting that many adolescents' mental disorders are not even diagnosed until after the juvenile justice system has taken custody of them); Anne Bowen Poulin, *Female Delinquents: Defining Their Place in the Justice System*, 1996 WIS. L. REV. 541, 544-51 (reporting that mentally ill youths frequently end up in state juvenile justice and child welfare systems where adequate community-based care is not necessarily available); John Dewese, *Editorial: Mental Health and Juvenile Justice*, WASH. POST, Apr. 30, 2003, at A22 (predicting that the fifty to seventy-five percent of incarcerated teens who have a diagnosable mental health disorder pose a high risk of recidivism unless they are treated and not merely "warehoused").

38. See Cichon, *supra* note 37, at 13 (claiming that the lack of community-based mental healthcare leads to frequent inpatient hospitalization of adolescents for "vaguely-defined behavioral and adjustment-related problems, mild depression, and nondependent drug and alcohol use"); Scott Higham & Sewell Chan, *Poor Care, Abuses Alleged at Riverside*, WASH. POST, Jul. 15, 2003, at A1 (reporting that one profit-motivated psychiatric hospital in the Washington, D.C. area admitted teens "to the [expensive] locked-down facility even though they didn't appear to have serious psychiatric problems").

39. See The Wellstone Mental Health Equitable Treatment Act of 2003, S. 486, 108th Cong. (2003) (addressing only private plans, as opposed to state-funded healthcare).

40. See Charles D. Weller, *The Secret Life of the Dominant Form of Managed Care: Self-Insured ERISA Networks*, 6 HEALTH MATRIX 305, 310 (1996) (providing a breakdown of types of health coverage in the United States).



form of health coverage offered in America.<sup>41</sup> In the vast minority are the fifteen million Americans who purchase individual insurance policies<sup>42</sup> and the unknown number who simply pay for mental healthcare out of their own pockets, sometimes at exorbitant costs.<sup>43</sup>

Medicaid provides fifty-five percent of all public funding to care for children,<sup>44</sup> but only provides mental healthcare in the most desperate cases.<sup>45</sup> Since states receive Medicaid funding in the form of block grants, they have the flexibility to determine which citizens are eligible for coverage, how and to what extent the state will provide mental health services, and whether it wants to “carve-out” the administration of mental healthcare by contracting with a private behavioral health company to provide these services.<sup>46</sup>

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41. See ERISA § 3, 29 U.S.C. § 1002(1) (1999) (defining “employee welfare benefit plan” as a plan maintained by an employer for the purpose of providing participants or their beneficiaries with benefits in the event of sickness or disability); see also EBRI Press Release, *supra* note 26 (reporting that more than sixty percent of American workers receive health insurance through their jobs); Sara Schaefer & Laurie McGinley, *Number of Americans Who Lack Health-Care Coverage Is Rising*, WALL ST. J., Sept. 30, 2003, at A1 (reporting that the number of Americans who receive employer-based health insurance declined slightly more than one percent between 2001 and 2002).

42. See Anne Maltz, *Health Insurance 101*, 690 PLI/LIT 523, 535 (noting that individual policies are the most expensive types of insurance because the individual lacks the scale and bargaining power that a large employer uses to negotiate lower rates); see also Mark A. Rothstein, *Predictive Genetic Testing for Alzheimer’s Disease in Long-Term Care Insurance*, 35 GA. L. REV. 707, 723 (2001) (explaining that individual insurance policies are regulated by the states, not by the federal government).

43. See GAO REPORT ON CHILD WELFARE, *supra* note 4, at 2 (noting that outpatient visits can cost \$100 per session and residential treatment facilities over \$250,000 per year for one child); see also Higham & Chan, *supra* note 38, at A8 (reporting that a private psychiatric facility for teens in the Washington, D.C. area charged \$700 per day for short-term acute care and \$250 per day for long-term counseling and medication).

44. See Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, 42 U.S.C. § 300x (Supp. IV 1992) (giving statistics on the various types of public healthcare).

45. See GAO REPORT ON CHILD WELFARE, *supra* note 4, at 12 (commenting that many states are not even aware of the additional flexibility afforded under the “Katie Beckett option”). This option enables states to use federal Medicaid dollars to fund health care in the home or community rather than solely in a controlled, institutional setting. *Id.*; see also Cichon, *supra* note 23, at 568 (noting that Medicaid covers mental health care only when the situation is urgent enough to warrant inpatient treatment). But see U.S. DEP’T OF HEALTH AND HUMAN SERV. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., THE COSTS AND EFFECTS OF PARITY FOR MENTAL HEALTH AND SUBSTANCE ABUSE INS. BENEFITS (1998) (commenting that public programs like Medicaid sometimes provide services that private insurers do not, such as psychosocial training and respite care for parents of mentally ill children), available at <http://www.mentalhealth.org/publications/allpubs/Mc99-80/prtych2.asp> (last visited Feb. 10, 2005).

46. See Maltz, *supra* note 42, at 536 (explaining that the federal government grants waivers to states, allowing them to deviate from the standard Medicaid plan); see also Anita Sharpe, *Psyched Up: More States Turn Over Mental-Health Care to the Private Sector*, WALL ST. J., Jan. 24, 1997, at A1 (querying whether states’ increased

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States have developed SCHIP to cover the five million uninsured children living in families whose incomes are too high to be eligible for Medicaid, but still lower than two hundred percent of the poverty level.<sup>47</sup> While SCHIP has provided healthcare to over two million children who might otherwise go without care, it still provides less access to mental healthcare than to medical or surgical care.<sup>48</sup> Even though states must provide mental healthcare under SCHIP, they can still charge higher premiums, deductibles, and co-payments for such services than for medical or surgical benefits.<sup>49</sup> However, these managed-care tactics may defeat the purpose of SCHIP by making state-funded mental healthcare too expensive for those who need it most.<sup>50</sup>

A mentally ill child faces another problem if her family's income rises above twice the federal poverty level or if she becomes eligible for private health insurance coverage under a parent's plan.<sup>51</sup> In that situation, the child loses the state-funded benefit even though a private insurer's mental health benefit might be non-existent or far inferior to what the child was receiving under SCHIP.<sup>52</sup> While some states have provided creative solutions to address this gap in

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reliance on carve-outs might lead to more institutionalization and fewer community-based services).

47. See NAT'L ALLIANCE OF THE MENTALLY ILL, POLICY UPDATE (reporting that the pending Family Opportunity Act, S. 622/H.R. 1811, 108th Cong. (2003), would also enable mentally ill children to receive the treatment they need, irrespective of whether they come from families whose income is too high to qualify for Medicaid), at <http://www.nami.org/policy/wherewestand/medicaid02.html> (last visited Feb. 10, 2005).

48. See NAT'L COUNCIL FOR CMY. BEHAVIORAL HEALTHCARE, POSITION STATEMENT ON SCHIP [hereinafter POSITION STATEMENT ON SCHIP] (commending SCHIP as the first instance of federally mandated public mental health services for children, but criticizing disparities that remain between the mental healthcare and medical care administered under the program), at <http://www.nccbh.org/html/policy/archives/schip.htm> (last visited Feb. 10, 2005).

49. Cf. Judy Greenwald, *Mental Health Parity Not as Costly as Feared*, BUS. OF INS., Jul. 31, 2000, at 1 (explaining that states are not the only entities using managed care techniques in an effort to stay cost-neutral). Sixty-five percent of employers surveyed were able to comply with the MHPA, 29 U.S.C. § 1185a (1999), only because they passed mental healthcare expenses on to their members in the form of higher premiums, co-payments, or deductibles. *Id.*

50. See POSITION STATEMENT ON SCHIP, *supra* note 48 (noting that these tactics are especially detrimental because "poor" (zero to ninety-nine percent of the poverty level) and 'low-income' (100-199 percent of the poverty level) children experience the highest rate of emotional and behavioral disorders").

51. See GAO REPORT ON CHILD WELFARE, *supra* note 4, at 5 (noting that differing eligibility requirements for Medicaid and other state-funded programs like SCHIP make it difficult for parents to obtain consistent care for their children).

52. But see, e.g., STATE OF ILL., DEP'T OF HUMAN SERV., EARLY INTERVENTION SERV. COORDINATION PUBLIC AND PRIVATE INS. USE DETERMINATION FORM (allowing those whose private insurance provides a lesser benefit than a state program to take advantage of state early intervention mental health services).

coverage,<sup>53</sup> only federal legislation requiring private insurers to provide a baseline of mental health coverage can guarantee continuity in services and ensure that a child's mental healthcare is not cut back or discontinued mid-treatment.<sup>54</sup>

Most Americans get their healthcare coverage through an "employee welfare plan" provided by their employers.<sup>55</sup> While American workers have come to expect such benefits, employers are under no legal obligation to offer health benefits.<sup>56</sup> An employer covers its employees' healthcare costs by either purchasing insurance or setting aside funds to pay these costs out of its own coffers.<sup>57</sup> The latter type of plan is referred to as "self-funded" or "self-insured."<sup>58</sup> Employers who self-insure enjoy two key benefits: 1) the plan is exempt from most state regulations, leaving employers the freedom to choose what, if any, health benefits they will provide employees and their dependents;<sup>59</sup> and 2) companies who self-insure do not have to pay taxes levied by states on insurance premiums.<sup>60</sup>

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53. See *id.* (exemplifying such a solution by providing early-intervention services to children notwithstanding their eligibility for private-payor insurance); Michael J. Carroll, *The Mental Health Parity Act of 1996: Let It Sunset If Real Changes Are Not Made*, 52 *DRAKE L. REV.* 553, 563 (2004) (asserting that more than thirty states required some form of mental health coverage between 1997 and 2001).

54. See Cichon, *supra* note 23, at 545 (noting that historically, federal involvement in providing mental healthcare has been "fragmented and inadequate").

55. See EBRI Press Release, *supra* note 26 (reporting that the number of employers offering welfare plans is holding steady but that fewer employees qualify for these plans, primarily because they work part-time).

56. See *Rush Prudential HMO, Inc.*, 536 U.S. at 402 (Thomas, J., dissenting) (reiterating that "no employer is required to provide [a] health benefit plan"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983) (commenting that federal law "does not mandate that employers provide any particular benefits").

57. See Maltz, *supra* note 42, at 534 (observing that even self-funded employers enjoy lower rates for treatment, prescription drugs, and related services and items than would an individual purchasing a stand-alone insurance plan).

58. See *id.* at 535 (explaining that self-insured plans are sometimes referred to informally as "ERISA plans" because they need only comply with the federal law); see also Michele Garvin et al., *Mental Health Parity: The Massachusetts Experience in Context*, 47 *B. B.J.* 18, 19 (2003) (recognizing that self-funded plans are not the only type exempt from state regulation). Taft-Hartley Trusts [funds established by collective bargaining agreements that provide health and welfare benefits to union members] also need only comply with ERISA since they cover members of unions who may reside in multiple states. *Id.*

59. But see ERISA § 510, 29 U.S.C. § 1140 (1999) (prohibiting an employer from firing an employee simply because the employer does not want to pay for his benefits under a plan); see also *Rush Prudential HMO, Inc.*, 536 U.S. at 373 (subjecting even self-funded plans to state regulation insofar as they offer an Health Maintenance Organization ("HMO") option to their participants).

60. See Laura J. Schacht, Note, *The Health Care Crisis: Improving Access for Employees Covered by Self-Insured Health Plans Under ERISA and the Americans with Disabilities Act*, 45 *WASH. U. J. URB. & CONTEMP. L.* 303, 343 (1994) (observing that exemption from premium taxes not only deprives states of an important revenue stream that supports public health programs, but also divests states of their ability to

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Although all employee welfare plans have the ability under federal law to “adopt, modify or terminate” those benefits at any time, self-insured companies do not need to answer to any state regulatory body when they make such cuts.<sup>61</sup> This ability to modify or eliminate mental health benefits at any point could lead to inadequate or inconsistent treatment of mental illnesses.<sup>62</sup>

## III. THE COST OF NATIONWIDE PARITY

Even though most states already have implemented “parity” in some form or another, advocates of national parity seek a cost-effective method of supplementing those state laws.<sup>63</sup> Most estimates predict that national parity would increase employers’ insurance premiums by less than one percent.<sup>64</sup> Because employee welfare plans that offer mental health treatment have implemented managed-care principles such as utilization review<sup>65</sup> and co-payments, the Mental Health Parity Act<sup>66</sup> (“MHPA”) has caused a negligible increase in costs to

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offer tax incentives to companies for compliance with reforms).

61. See, e.g., *Pisciotta v. Teledyne Indus., Inc.*, 91 F.3d 1326, 1330-31 (9th Cir. 1996) (affirming even an insured employer’s right to place a monetary cap on retirees’ healthcare benefits); *Doe v. Group Hospitalization & Med. Services*, 3 F.3d 80, 84 (4th Cir. 1993) (stating that employers may “modify or withdraw . . . benefits at any time, provided that the changes are made in compliance with the terms of the plan”).

62. See Schacht, *supra* note 60, at 312 (warning that self-insurance gives employers more flexibility to eliminate coverage for mental health or substance-abuse treatment).

63. Compare MONT. CODE ANN. § 33-22-703 (2001) (requiring, *inter alia*, every group health plan or health insurance issuer to cover treatment of most mental health and substance abuse diagnoses at the same durational limits, dollar limits, deductibles, and coinsurance factors as physical health insurance), with CAL. INS. CODE § 10144.5 (1999) (requiring coverage of only the “medically necessary treatment” of adults for enumerated “severe mental illnesses” (including schizophrenia, bipolar disorder, and major depressive disorders) but mandating coverage of children for all disorders listed in the then-current *DSM*), and MINN. STAT. § 62A.152 (2002) (mandating, *inter alia*, equal coverage of “at least eighty percent of the cost of the usual and customary charges of the first ten hours of [outpatient] treatment incurred over a twelve-month benefit period”).

64. See GEN. ACCOUNTING OFFICE, MENTAL HEALTH PARITY ACT: DESPITE NEW FED. STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED 4 (2000) [hereinafter GAO MENTAL HEALTH PARITY ACT] (surveying 1,656 employers to assess whether compliance with the MHPA, 29 U.S.C. § 1185a (1999), resulted in increased cost or utilization of mental health services by their employees). But see Jensen & Morrissey, *supra* note 11, at 9 (commenting that benefit mandates force employers to cut back other ways in which they compensate their employees, such as wages and non-health fringe benefits).

65. See Michael A. Dowell, *Avoiding HMO Liability for Utilization Review*, 23 U. TOL. L. REV. 117, 117 (1991) (defining “utilization review” as a process by which medical professionals employed by insurance companies evaluate the necessity of a given treatment to control costs). Utilization review may result in the denial of benefits, even after a patient has received treatment, thus making the patient liable for the cost. *Id.*

66. 29 U.S.C. § 1185a (1999) (forbidding insurance plans that provide mental

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employers.<sup>67</sup> Although managed-care essentially passes the cost of care onto those who use services the most, it seems to be the only way to make parity palatable to legislators.<sup>68</sup>

Many employers have implemented managed care techniques for mental/behavioral illnesses by using third-party healthcare delivery systems (also known as “carve-outs”) such as Magellan, Behavioral Healthcare, Horizon Health, and Universal Health Services to administer their plans’ mental health benefits.<sup>69</sup> These third-parties focus solely on the management of mental and behavioral healthcare and have been very successful in helping employers control the cost of mental healthcare.<sup>70</sup>

#### IV. FEDERAL LAW HAS UNDERMINED STATES’ EFFORTS TO PROVIDE MENTAL HEALTHCARE TO CHILDREN AND TEENS

ERISA<sup>71</sup> is the federal law that regulates pensions and “employee welfare plans.”<sup>72</sup> ERISA establishes judicial remedies for aggrieved participants,<sup>73</sup> internal claims procedures,<sup>74</sup> mandatory disclosure of

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health services from applying a lifetime cap on benefits that is lower than any cap they would place on physical or medical coverage).

67. See *Achieving Parity for Mental Health Treatment: Hearing on S. 543 Before the Senate Comm. on Health, Educ. Labor, & Pensions*, 107th Cong. 4 (statement of Henry Harbin, witness) (indicating that companies who hired third-party behavioral health providers experienced premium increases of less than one percent following MHPA implementation); see also GAO MENTAL HEALTH PARITY ACT, *supra* note 64 (reporting that few employers surveyed reported any increase in the overall cost of their claims three years after passage of the MHPA, 29 U.S.C. § 1185a (1999)); Greenwald, *supra* note 49, at 1 (noting that most employers have stayed cost-neutral since complying with the MHPA).

68. See Harrison, *supra* note 6, at 255 (noting the “great irony” of managed care in the context of parity: decreasing the effectiveness of managed care increases parity’s acceptability to legislators).

69. See Garvin, *supra* note 58, at 19 (questioning whether third-party mental health providers will provide care that is “separate but equal” when compared with medical services under the same plan or whether these carve-outs will lead to an inferior level of care); see also Kirschstein, *supra* note 10, at 12 (reporting that use of carve-outs can halve per-member costs while increasing the proportion of the population receiving mental health services and increasing overall access).

70. See *Talk of the Nation*, *supra* note 30 (reporting the potential for a five to eight percent increase in premiums across the board unless a company hires a third-party mental health management organization); see also Satel & Humphreys, *supra* note 25, at 24 (quoting the National Mental Health Association as claiming that “parity in conjunction with managed care results in a thirty to fifty percent decrease in total mental health costs”).

71. 29 U.S.C. § § 1001-1461 (1999).

72. See 29 U.S.C. § 1002(1) (defining “employee welfare/benefit plan” as a plan “established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise”).

73. See 29 U.S.C. § 1132 (establishing a private right of action for a participant, beneficiary, or fiduciary to sue to recover benefits due).

74. See 29 U.S.C. § 1133 (requiring every plan to establish an appeals procedure

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certain information to participants,<sup>75</sup> and standards of conduct for plan administrators.<sup>76</sup> At first blush, these formal requirements make ERISA seem like an employee-friendly statute that was created to help protect employees' benefits.<sup>77</sup>

Despite its employee-friendly visage, however, ERISA did not create the level of employee-protection that some legislators envisioned.<sup>78</sup> Its primary objectives were benefiting big businesses by creating a baseline of uniformity and minimizing the administrative burden on employers who employ workers in multiple states.<sup>79</sup> In spite of its formal requirements, ERISA places no *substantive* requirements on the content of employee welfare plans.<sup>80</sup> In fact, ERISA does not require that employers provide any health benefits whatsoever.<sup>81</sup> As compared to other benefits, such as pensions, 401(k) plans, and employee stock option plans, the substance of employee health insurance plans is the lawless, "Wild West" of employee benefits.<sup>82</sup>

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whereby a participant receives a written notice of denial of a benefit and has a reasonable opportunity to have that denial reviewed by the plan fiduciary).

75. See 29 U.S.C. §§ 1021-1031 (mandating that all plans publish such disclosures in a Summary Plan Description, Annual Report, and documents informing participants of their rights).

76. See 29 U.S.C. § 1002(21)(A) (defining a "fiduciary" as a person who exercises discretionary control over the management of a plan); 29 U.S.C. § 1104 (instructing fiduciaries to exercise greater than ordinary skill and care in managing an ERISA plan).

77. See *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (finding legislative intent to "protect contractually defined benefits"); *Shaw*, 463 U.S. at 90 (declaring that Congress enacted ERISA to "promote the interest of employees and their beneficiaries in employee benefit plans"); 120 Cong. Rec. 29,194 (daily ed. Aug. 20, 1974) (statement of Rep. Biaggi) (declaring that "workers are receiving their own version of an emancipation proclamation"); see also 120 Cong. Rec. 29,951 (daily ed. Aug. 22, 1974) (remarks of Sen. Bentsen) (predicting that ERISA will "establish . . . standards to insure honest, faithful, and competent management of pension and welfare funds").

78. See David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 475 (1987) (cautioning that employees might find themselves "victimized, rather than protected by ERISA").

79. See ERISA § 2, 29 U.S.C. § 1001(a) (1999) (evinced congressional intent to provide uniformity to facilitate large, multi-state employers' provision of health benefits to their employees); see also *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987) (declaring that preemption is appropriate to avoid a "patchwork scheme of regulation that would introduce considerable inefficiencies in benefit program operation"); see also *Shaw*, 463 U.S. at 107 (interpreting the legislature's intent to simplify healthcare compliance for companies that employ in multiple states). But see Gregory, *supra* note 78, at 454 (noting that the policy objectives of uniformity and simplicity were intended to benefit employees indirectly by encouraging employers to develop plans).

80. See ERISA § 2, 29 U.S.C. § 1001 (1999) (stating ERISA's intent to encourage the growth and maintenance of *pension* plans, *not* employee welfare plans).

81. See *Pegram v. Herdrich*, 530 U.S. 211, 226-27 (2000) (stating that federal law neither mandates the content of employee benefit plans nor requires that employers offer such plans).

82. See ERISA § 201(1), 29 U.S.C. § 1051(a)(1) (1999) (exempting employee

Towards this goal of uniformity, ERISA preempts state regulation of employee benefit plans.<sup>83</sup> While an entire body of law and legal analysis has developed around defining the scope of preemption,<sup>84</sup> the legislative history reveals that neither the original House nor Senate bills contemplated a preemption clause quite as broad as the one that became law.<sup>85</sup> Preemption hampers states' abilities to offer parity to their citizens in several ways. Legislatively, states cannot effectively regulate the many self-funded plans that offer benefits to their citizens.<sup>86</sup> Judicially, plaintiffs may lose the opportunity to adjudicate the matter in state court, the more plaintiff-friendly venue,<sup>87</sup> as well as the right to pursue causes of action grounded in state law.<sup>88</sup>

Preemption severely affects states' abilities to legislate mental health

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welfare plans from the vesting requirements placed on pensions and other benefits); see also Edward A. Zelinsky, *Against a Federal Patients' Bill of Rights*, 21 YALE L. & POL'Y REV. 443, 446-47 (2003) (noting that ERISA regulates the form but not the substance of welfare benefits). This "regulatory gap" can also be characterized as a zone of "employer autonomy," depending on which side of the parity debate one represents. *Id.*

83. See Preemption Clause, ERISA § 514, 29 U.S.C. § 1144 (1999) (stating that ERISA "shall supersede any and all state laws insofar as they may now or hereafter relate to any 'employee welfare plan'"); see also *Shaw*, 463 U.S. at 96-97 (interpreting section 514 of ERISA broadly to preempt any law that has "a connection or reference to such a plan").

84. See, e.g., *Kuhl v. Lincoln Nat'l Health Plan, Inc.*, 999 F.2d 298, 302 (8th Cir. 1993) (recognizing that precedent had not provided a clear-cut method for determining the scope of preemption, but acknowledging congressional intent that ERISA "cut a wide swath of preemption through state laws"); see also *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) (noting that ERISA's "pre-emption clause is conspicuous for its breadth").

85. See, e.g., S. 1557, 93d Cong. 1st Sess. (1973) (preempting only laws relating to the fiduciary, reporting, and disclosure responsibilities of persons acting on behalf of employee benefit plans); see also H.R. 9824 93d Cong. 1st Sess. (1973) (containing no preemption provision whatsoever).

86. See Jensen & Morrissey, *supra* note 11, at 9 (noting that a state insurance mandate such as parity only impacts about thirty-three to forty-two percent of a state's population, in part due to the self-insurance phenomenon).

87. See *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 59 (1987) (finding that ERISA preemption is so powerful a defense that it can remove a case to federal court); Neal Miller, *An Empirical Study of Forum Choices in Removal Cases Under Diversity and Federal Question Jurisdiction*, 41 AM. U. L. REV. 369, 402-04 (1992) (reporting that plaintiffs' attorneys prefer to remain in state court due to factors such as geographic convenience, familiarity, and the relative absence of burdensome pretrial requirements). Likewise, defense attorneys prefer to remove to federal court simply to counter whatever advantage plaintiffs' counsel thought would come from filing in state court. *Id.*

88. See, e.g., *Aetna Health, Inc. v. Davila*, 124 S. Ct. 2488 (2004) (forbidding the plaintiffs from seeking relief under state law for the alleged failures of their HMOs to exercise ordinary care in making coverage decisions); see also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987) (denying a plaintiff's access to state-law remedy because ERISA preempted the cause of action).

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parity for children and adolescents.<sup>89</sup> By exempting many welfare plans from having to comply with state law and preserving only a very limited class of regulations from preemption,<sup>90</sup> ERISA severely limits the efficacy of even the most progressive states' attempts at parity.<sup>91</sup> In the courtroom, ERISA's preemption clause<sup>92</sup> strips states of their abilities to enforce any laws that "relate to" ERISA plans.<sup>93</sup> A law "relate[s] to" an ERISA plan as long as it is not a law of general applicability and does not have a connection to ERISA that is "remote or peripheral."<sup>94</sup> In *Firestone Tire & Rubber Co. v. Neusseran*,<sup>95</sup> the Sixth Circuit clarified "remote or peripheral" by noting that a state law is saved from preemption if it: (1) is an exercise of traditional state authority;<sup>96</sup> (2) does not affect relationships among the traditional ERISA entities (the employer, plan participants, fiduciaries, and beneficiaries); or (3) affects an ERISA plan merely incidentally.<sup>97</sup>

If a state law regulates insurance, however, it may not be preempted, even though it might "relate to" an ERISA plan.<sup>98</sup> The Savings Clause<sup>99</sup> preserves states' rights to regulate insurance companies by exempting from preemption any state regulations aimed at insurance companies.<sup>100</sup> Congress has provided several tools

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89. See Jensen & Morrisey, *supra* note 11 (reporting that a state insurance mandate such as parity only reaches about a third of a given state's population).

90. See Savings Clause, ERISA § 514(a)(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1999) (stating that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities").

91. See GAO MENTAL HEALTH PARITY ACT, *supra* note 64, at 6-7 (2000) (reporting that sixteen states require a more rigorous form of parity than does currently pending Congressional legislation). These statutes require insurers to offer mental healthcare to every medical/surgical plan participant. *Id.*

92. Preemption Clause, ERISA § 514(a), 29 U.S.C. § 1144(a) (1999).

93. See ERISA § 514(a) (stating that ERISA supercedes all state laws relating to employee benefit plans as of January 1, 1975).

94. See *Bucyrus-Erie Co. v. Dep't of Indus., Lab. & Hum. Rel.*, 599 F.2d 205, 208-10 (7th Cir. 1979) (stating that courts should assume a statute "relate[s] to" an employee benefit plan unless extreme circumstances indicate otherwise).

95. 810 F.2d 550, 555-56 (6th Cir. 1987).

96. See *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 231 (1946) (articulating the assumption that the historic police power of a state should not be trumped in the absence of express congressional intent); *West Coast Hotel v. Parrish*, 300 U.S. 379, 391 (1937) (finding that states have the power to make laws regulating the health, safety, morals, and general welfare of their citizens).

97. See *Firestone Tire & Rubber Co.*, 810 F.2d at 555-56 (noting that these factors are mere guidelines). Not all factors must be fulfilled for a state law to survive preemption; the factors are not exhaustive, and no single factor is dispositive. *Id.* at 556.

98. See Savings Clause, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1999) (stating that "nothing in [ERISA] shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities").

99. ERISA § 514(b)(2)(A).

100. See ERISA § 514(b)(2)(A) (allowing states to regulate insurance, banking, or



to help determine whether an entity is subject to the Savings Clause.<sup>101</sup>

In *Metropolitan Life Insurance Co. v. Massachusetts*,<sup>102</sup> the Supreme Court established a “common-sense” test for determining whether a law regulates the insurance industry.<sup>103</sup> According to this test, courts interpret “relates to” in the normal sense of the phrase: having “a connection with or reference to” a state insurance regulation.<sup>104</sup> The Court further clarified this test in *Pilot Life Insurance*<sup>105</sup> by specifying that, to escape preemption, a law must have been developed specifically to regulate the insurance industry and not merely have an impact on it.<sup>106</sup>

Following common-sense analysis,<sup>107</sup> a court evaluates a state regulation according to the McCarran-Ferguson Act, which underscores states’ rights to regulate the “business of insurance” within their borders.<sup>108</sup> In *Union Labor Life Insurance Co. v. Pireno*,<sup>109</sup> judicial interpretation of the McCarran-Ferguson Act<sup>110</sup> yielded the following criteria for courts to use when ascertaining whether a regulated practice is “insurance”: (1) whether the practice spreads risk; (2) whether the practice is an integral part of the relationship between insured and insurer; and (3) whether the practice is limited to entities within the insurance industry.<sup>111</sup> The *Union Labor* court noted that no single guidepost is determinative.<sup>112</sup>

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securities entities that operate within their borders).

101. See, e.g., Deemer Clause, ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1999) (stipulating that employee benefit plans are not insurance companies, in and of themselves); see also McCarran-Ferguson Act, 15 U.S.C. § 1011 (1994) (providing guideposts to help courts interpret the Deemer Clause and determine whether a practice is part of the “business of insurance” and, therefore, subject to state law).

102. 471 U.S. 724 (1985).

103. See *Metropolitan Life Ins. Co.*, 471 U.S. at 739 (saving from preemption a state law requiring a specified level of mental health coverage).

104. See *id.* (attaching a broad common-sense meaning to the phrase “relates to”).

105. 481 U.S. 42 (1987).

106. See *id.* at 50 (preempting a claim for insurance bad faith even though ERISA clearly regulated the insurance industry because the tort of bad faith developed independently, and not exclusively to prosecute the insurance industry).

107. See *Metropolitan Life Ins. Co.*, 471 U.S. at 740 (stating that courts should use “common-sense” in determining whether a law “regulates insurance” under ERISA’s Savings Clause).

108. 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. § 1011 (1994)); see also *Rush Prudential HMO, Inc.*, 536 U.S. at 366 (requiring courts to use the “common-sense test” and McCarran-Ferguson Act, 15 U.S.C. § 1011, in tandem to assess the types of laws and companies that states subject to regulation).

109. 458 U.S. 119, 129 (1982).

110. See 15 U.S.C. § 1011 (reinforcing the Savings Clause).

111. *Union Labor Life Ins. Co.*, 458 U.S. at 129.

112. See *id.* (demonstrating the Court’s use of all three McCarran-Ferguson factors

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Rather, it held that a court must evaluate all three and decide whether, as a whole, the regulated practice is within the “business of insurance.”<sup>113</sup>

Because a self-insured group welfare plan is not an insurance company per se,<sup>114</sup> the only plans that must abide by state laws are those that actually purchase policies from insurance companies.<sup>115</sup> As a result, employers can self-insure simply to avoid the costs of providing their employees the benefits that their state legislatures have deemed important enough to mandate.<sup>116</sup>

Even though the scope of preemption has narrowed in recent years and the Supreme Court has declared a presumption against it,<sup>117</sup> preemption remains a hurdle that plaintiffs must clear when suing to recover wrongfully denied mental health benefits.<sup>118</sup> In contradiction to the presumption against preemption that it articulated in *Metropolitan Life Insurance Co. v. Massachusetts*,<sup>119</sup> the Court has since justified preemption by citing ERISA’s broad legislative intent to provide uniformity.<sup>120</sup> While the Court has provided little guidance

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in its analysis).

113. See *id.* (determining that an insurance company’s use of a peer review system was not regulable at the state level because it did not involve risk-spreading, was not an integral part of the relationship between an insurer and plan participants, and was not limited to entities within the insurance industry).

114. See Deemer Clause, 29 U.S.C. § 1144(b)(2)(B) (stipulating that employee benefit plans are free from state regulation unless they purchase insurance); see also Schacht, *supra* note 60, at 317 (noting that self-insured plans do not meet the third prong of the *Union Labor* factors and, therefore, evade state regulation).

115. See Schacht, *supra* note 60, at 304 n.45 (reporting that federal circuits are divided regarding whether plans that purchase stop-loss insurance [a special form of coverage purchased by self-insured employers to preclude financial inability to pay for all of their employees’ claims in a given year] are subject to state regulation).

116. See *id.* at 343 n.33 (reporting that benefit consultants often advise their clients to self-insure specifically to skirt state regulation and taxation of insurance premiums). But see Jensen & Morrissey, *supra* note 11, at 15 (countering the assertion that employers self-insure just to avoid complying with state benefit mandates and stating that avoidance of premiums and taxes on premiums is the greatest incentive to self-insure).

117. See *Metropolitan Life Ins. Co.*, 471 U.S. at 741 (declaring that “the presumption is against pre-emption, and [the Court is] not inclined to enlarge the pre-emptive scope of ERISA”).

118. See *Rush Prudential HMO, Inc.*, 536 U.S. at 402 (narrowing preemption by preserving state regulation of the relationship between HMOs and primary care physicians); *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (turning the tide against preemption by preserving a New York law that collected surcharges from certain health plans but not others). But see, e.g., *Marks v. Watters*, 322 F.3d 316, 327 (4th Cir. 2003) (representing the vast majority of cases in which ERISA preempted a state law claim regarding denial of a mental health benefit determination or utilization review).

119. 471 U.S. 724, 736 (1985).

120. See ERISA § 2, 29 U.S.C. § 1001(a) (1999) (evinced congressional intent to provide uniformity to enable large, multi-state employers to provide health benefits to their employees); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987) (declaring

to help resolve this inconsistency, it seems to apply the doctrine of preemption liberally except where the state law or cause of action: regulates insurance;<sup>121</sup> affects a plan in a manner that is too “tenuous, remote, or peripheral” to “relate to” an ERISA plan;<sup>122</sup> or is a “law of general applicability.”<sup>123</sup>

#### V. REMEDIES AVAILABLE TO AGGRIEVED FAMILIES

Until we have a federal law mandating parity, ERISA is the law under which a court evaluates a case like that of the O’Clair family.<sup>124</sup> As a result of ERISA preemption, even families who are fortunate enough to have mental health coverage through their employers have little hope of attaining a meaningful recovery when a dependent or other plan participant dies as a result of the health plan’s policies, decisions, actions, or inactions.<sup>125</sup>

The following analysis hypothesizes the type of result plaintiffs like the O’Clairs might expect under current law if they were to seek judicial redress for their loss.<sup>126</sup> First, a court would ascertain whether the plan at issue is an employee welfare plan, as defined by ERISA.<sup>127</sup> If a plan is not a group employee welfare plan or is a type of plan specifically exempted from compliance with ERISA (e.g., a church or government-employee plan), state law governs it.<sup>128</sup> Once a court

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that preemption is appropriate in order to avoid a “patchwork scheme of regulation that would introduce considerable inefficiencies in benefit program operation”).

121. See Savings Clause, ERISA § 514 (b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1999) (saving from preemption state laws that regulate insurance).

122. *But see Shaw*, 463 U.S. at 100 n.21 (finding that even a “Human Rights Law” affected a plan proximately enough to “relate to” an ERISA plan).

123. See *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 825 (1988) (holding that ERISA did not preempt general state garnishment procedures used to collect judgments even where those procedures are used to collect judgments against participants of an ERISA plan).

124. See *supra* Introduction (discussing the O’Clair family’s tragic loss of their son, Timothy, to a mental illness). Parity could have provided Timothy with inpatient treatment that might have prevented his death. *Id.*

125. See *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (holding that ERISA preemption prevented a decedent’s family from suing the decedent’s employer for wrongful death, improper refusal to authorize benefits, medical malpractice, and insurance bad faith). No recovery was available to the family, even under ERISA, because the employer had reserved the right to refuse to authorize psychiatric treatment under the terms of the plan. *Id.*

126. See *supra* Introduction (recounting the story of Timothy O’Clair’s mental illness and eventual suicide).

127. See ERISA § 3, 29 U.S.C. § 1002(1) (1999) (providing ERISA’s definition of “employee welfare/benefit plan”); *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993) (declining to recognize as an “employee welfare plan” a policy purchased by a sole proprietor to cover himself and his wife but not any of his employees).

128. See ERISA § 4, 29 U.S.C. § 1003(b) (1999) (exempting the following types of plans from compliance with ERISA: any government-employee plan; church plans; plans maintained solely for the purpose of complying with disability, workman’s

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determines that the plan at issue is an employee welfare plan, it would then seek to understand whether it is a self-insured plan, subject only to federal law.<sup>129</sup>

The next hurdle that a plaintiff would have to clear is the determination of whether the claim is appropriately heard by a state or federal court.<sup>130</sup> In *Metropolitan Life Insurance Co. v. Taylor*,<sup>131</sup> the Supreme Court held that ERISA's preemptive provisions<sup>132</sup> are grounds for removal to federal court. Even though no question of federal law appears on the face of the complaint,<sup>133</sup> asserting ERISA preemption as a defense automatically confers federal jurisdiction as an exception to the "well-pleaded complaint" rule.<sup>134</sup> Assuming that the O'Clairs' insurance company would assert a preemption defense, the claim probably would be removed to federal court to determine whether their claim actually is preempted and what remedy, if any, is appropriate.<sup>135</sup>

The next issue is whether the statute supporting a plaintiff's cause of action "relate[s] to" his plan.<sup>136</sup> Once a court determines that a state regulation is sufficiently "relate[d] to" an ERISA plan, it considers whether the law regulates insurance, such that it is saved

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compensation, or unemployment insurance laws; and excess benefit plans that provide benefits to highly compensated employees); see, e.g., A. 08301/S. 5329, 226th Leg., (N.Y. 2003) (demonstrating a state parity law that would apply to the types of plans enumerated in section four of ERISA).

129. See Jensen & Morrissey, *supra* note 11, at 9 (discussing the trend towards self-insurance and the concomitant increase in the number of plans exempt from state regulations).

130. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 59 (1987) (establishing that the defense of ERISA preemption can support removal to federal court).

131. 481 U.S. 58, 59 (1987).

132. ERISA § 514(a), 29 U.S.C. § 1144(a).

133. See 28 U.S.C. § 1441(b) (2002) (stipulating requirements for removal to federal court).

134. See *Louisville & Nashville R.R. Co. v. Mottley*, 211 U.S. 149, 152 (1908) (finding an anticipated defense based on federal law insufficient to establish a well-pleaded complaint and thus justify removal); see, e.g., *Wayne Chem. v. Columbus Agency Serv. Corp.*, 426 F. Supp. 316 (N.D. Ind. 1977), *aff'd as modified by*, 567 F.2d 692 (7th Cir. 1977) (finding removal to federal court proper where a beneficiary sued to enforce rights under an ERISA plan). *But see* *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 354 (3d Cir. 1994) (narrowing *Metropolitan Life Insurance Co.* by noting that not all preemption-based defenses are strong enough to automatically merit removal where no question of federal law appears on the face of the complaint).

135. See *Holt v. Tonawanda Coke-Corp.*, 802 F. Supp. 866, 872 (W.D.N.Y. 1991) (holding that a case is removable if conduct alleged by a plaintiff is actionable under ERISA).

136. See *Metropolitan Life Ins. Co.*, 471 U.S. at 739 (stating that ERISA only preempts those state laws that "relate to" an ERISA plan). See generally *supra* Part IV (discussing circumstances under which preemption is not appropriate, such as where a state regulation's connection with an ERISA plan is too "tenuous" or "remote").

from preemption.<sup>137</sup> If a state had no parity law in place at the time benefits were denied, that plaintiff would lack a state law “hook” on which to base his claim.<sup>138</sup>

Irrespective of the outcome of common-sense analysis, however, ERISA preempts a cause of action if section 502(a)<sup>139</sup> also provides a remedy for the plaintiff’s claims.<sup>140</sup> Section 502(a) of ERISA<sup>141</sup> only provides a remedy for the following causes of action: 1) recovery of benefits due under a plan (i.e., improper processing of a claim); 2) enforcement of rights under the terms of the plan; and 3) clarification of future benefits.<sup>142</sup> Therefore, if section 502(a) of ERISA provides a remedy for any part of the O’Clair family’s claim, it would foreclose their possibility for recovery under state law theories.<sup>143</sup>

#### VI. ADA AS AN ALTERNATIVE BASIS FOR RELIEF

Some authors have recommended that, as an alternative tactic, victims of insurance discrimination base their cases on the ADA.<sup>144</sup> This is not a viable cause of action for children and adolescents, however, because they are, generally, mere dependents of the

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137. See *Metropolitan Life Ins. Co.*, 471 U.S. at 740 (establishing a common-sense standard for determining whether a law “regulates insurance” but requiring that the law specifically address the insurance industry, rather than merely affecting it peripherally, to withstand judicial scrutiny).

138. See GAO MENTAL HEALTH PARITY ACT, *supra* note 64, at 6-7 (noting that seven states have no parity laws whatsoever).

139. See ERISA § 502(a), 29 U.S.C. § 1132(a)(1)(B) (1999) (enabling a plan participant to recover benefits due under a plan, to enforce rights under the terms of a plan, or to clarify his rights to future benefits).

140. ERISA § 502(a), 29 U.S.C. § 1132(a) (1999); see also *Pilot Life Ins. Co.*, 481 U.S. at 56 (declaring that preemption of a state cause of action is appropriate even where the state remedy merely supplements or offers an alternative remedy to that offered by ERISA). But see *Rush Prudential HMO, Inc.*, 536 U.S. at 400 (holding that a state statute may provide a supplemental remedy where that statute regulates insurance and is, therefore, preserved by the Savings Clause).

141. 29 U.S.C. § 1132(a).

142. See ERISA § 502(a) (enumerating the types of private rights of action ERISA provides to plan members and beneficiaries); see, e.g., *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (declaring that utilization review is a means of processing claims and, therefore, falls under section 502). Because section 502 provided the *Tolton* plaintiffs with some relief, they were not eligible for state-law remedies. *Id.*

143. See ERISA § 502(a), 29 U.S.C. § 1132(a); see also *Pilot Life Ins. Co.*, 481 U.S. at 52 (finding clear congressional intent that section 502(a) was to be the “exclusive vehicle for action by ERISA-plan participants and beneficiaries” to keep plan providers from having to defend against a variety of state causes of action).

144. See Americans with Disabilities Act, 42 U.S.C. § 12101 (1994) (prohibiting workplace discrimination against individuals with disabilities); see, e.g., Nelson, *supra* note 17, at 21 (exploring whether the ADA is a viable basis for challenging a denial of mental health benefits).

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employed and not employees themselves.<sup>145</sup> ADA empowers a disabled plaintiff to sue an employer (or potential employer) who is not willing to make certain reasonable changes to the work environment that would enable the disabled employee to do her job.<sup>146</sup> Under this theory, the ADA would enable employees who cannot obtain treatment for their mental illness through their employer-sponsored insurance plan to sue their employers for failing to provide treatment as a “reasonable accommodation” of a disability.<sup>147</sup>

This approach is problematic for several reasons.<sup>148</sup> First, it only provides a remedy to a small segment of the mentally ill population.<sup>149</sup> It would exclude those whose mental illnesses do not “substantially limit” their abilities to work.<sup>150</sup> Under that test, those with mild, temporary, or sporadic, but nevertheless debilitating, illnesses will have no remedy.<sup>151</sup> This approach would only help those who function well enough to obtain a job and perform the “essential functions” of the job without assistance.<sup>152</sup> This stipulation completely excludes those who are so mentally ill that they cannot work.<sup>153</sup> Those teens who also abuse illegal drugs, sometimes as an ersatz coping mechanism when they cannot obtain mental healthcare,

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145. See ADA, 42 U.S.C. § 12111(9) (mandating that employers provide “reasonable accommodation” of disabilities to their employees, but not to employees’ family members).

146. See ADA, 42 U.S.C. § 12101 (leaving open the possibility that a mental illness could be considered a disability).

147. See Nelson, *supra* note 17, at 128, 135 (applying the facts of mental illness to the elements of a *prima facie* case of employment discrimination under the ADA and recommending that future parity plaintiffs characterize their mental illnesses as a “disability”).

148. See, e.g., EEOC v. Staten Island Sav. Bank, 207 F.3d 144, 149-50 (2000) (taking the position that limitations on mental healthcare are not a violation of the ADA because they impact all participants equally, irrespective of whether they have a mental illness).

149. See *infra* notes 150-156 (enumerating all of the mentally ill populations that are ineligible for a remedy under the ADA).

150. See ADA, 42 U.S.C. § 12102(2) (defining “disability” as a “physical or mental impairment that substantially limits one or more major life activities”); see also Fuller v. Iowa Dept. of Human Services, 576 N.W.2d 324, 333 (Iowa 1998) (finding that a plaintiff’s mental depression did not constitute a qualified disability because she was able to control it with medication).

151. See, e.g., Sanders v. Arneson Products, Inc., 91 F.3d 1351 (9th Cir. 1996), *cert. denied*, 520 U.S. 1116 (1997) (holding that an employee’s temporary, four-month psychological impairment was of insufficient duration to constitute a “disability” under the ADA).

152. See ADA, 42 U.S.C. § 12111(8) (giving the employer discretion to determine which tasks comprise the “essential functions” of the position).

153. See Nelson, *supra* note 17, at 137 (acknowledging that the ADA is not a broad-based remedy for the mentally ill).

comprise another group left without a remedy under the ADA.<sup>154</sup>

Second, a plaintiff suing under the ADA would have to show actual discrimination (i.e., an adverse employment decision based on the disability).<sup>155</sup> Finally, the ADA would do nothing to help child and adolescent dependents, like Timothy O'Clair, since the statute does not compel employers to accommodate dependent family members, only employees.<sup>156</sup>

#### VII. FEDERAL LEGISLATION, SUCH AS THE WELLSTONE ACT, CAN CLOSE THE REGULATORY GAP LEFT BY ERISA

Because preemption creates a regulatory scheme whereby many employee welfare plans escape state regulation, congressional legislation is the only means of closing that gap and achieving parity.<sup>157</sup> Irrespective of parity gains on the state level, federal legislation is required to provide a baseline of parity.<sup>158</sup>

Without accompanying federal legislation, a multiplicity of inconsistent state regulations could create a "race to the bottom" whereby employers flee from states that mandate mental health parity.<sup>159</sup> While the high cost to an employer of picking up and moving to another state makes this possibility remote, it is conceivable

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154. See ADA, 42 U.S.C. § 12210(a) (excluding individuals currently using illegal drugs from classification as an "individual with a disability"); see also NAT'L COUNCIL FOR CMY. BEHAVIORAL HEALTHCARE, CO-OCCURRING MENTAL HEALTH AND ADDICTIONS TREATMENT DISORDERS (acknowledging the co-morbidity between mental illness and substance abuse by noting that substance abuse is the "expectation, not the exception" among the mentally ill), at <http://www.nccbh.org/POLICY/Position/co-occurringP.htm> (last visited Feb. 10, 2005); SUBSTANCE ABUSE SERVICE UNDER SCHIP, *supra* note 29, at 22 (reporting that many adolescents with severe emotional disorders also have substance abuse problems).

155. See, e.g., *Andrews v. Ohio*, 104 F.3d 803, 807 (6th Cir. 1997) (requiring a successful ADA plaintiff to show that while the defendant perceived him to be handicapped, he regarded him as otherwise qualified for the job and discriminated against him solely on the basis of his disability).

156. Compare ERISA § 3(8), 29 U.S.C. § 1002 (8) (1999) (covering employees and their "beneficiaries," usually family members), with ADA, 42 U.S.C. § 12111(9) (affording "reasonable accommodation" to employees, but not to their family members).

157. See *Jensen & Morrissey*, *supra* note 11, at 10 (commenting that plans offered by a majority of large companies are able to self-insure and thus avoid all regulation except that administered by the federal government).

158. See *Zelinsky*, *supra* note 17, at 460 (acknowledging that national minimum standards are sometimes the sole means of promulgating important social policy).

159. See *id.* (reviewing proponents and critics' "race to the bottom" analysis); cf. William L. Cary, *Federalism and Corporate Law: Reflections Upon Delaware*, 83 YALE L.J. 663, 663-66 (1974) (noting that diversity in state regulation of corporations, for example, leads the states to compete with one another to entice businesses to incorporate there). This competition may operate to the detriment of shareholders' rights because corporations tend to incorporate in the states where regulations are the most permissive. *Id.*

that the costs of moving could be less than the costs of complying with a state parity regulation that an employer finds particularly onerous.<sup>160</sup> While preventing a “race to the bottom” might be one reason for passing federal legislation, there are a multitude of other, better reasons for mandating parity from the top-down through federal legislation.<sup>161</sup> The strongest of these reasons is closing the regulatory gap by supporting states’ rights to regulate businesses that employ their citizens.<sup>162</sup>

Congress could address the regulatory gap by passing any of the following types of legislation: 1) amendment of ERISA’s preemption clause<sup>163</sup> that would permit (but not require) states to regulate self-funded health plans; 2) a federal mental health parity act more demanding than either the recently expired MHPA<sup>164</sup> or the proposed Wellstone Act;<sup>165</sup> or 3) amendment of ERISA to require vesting of employee welfare plan benefits.<sup>166</sup>

#### *A. Amending ERISA’s Preemption Clause*

Repeal of ERISA’s Preemption Clause<sup>167</sup> would represent a drastic measure that would destroy ERISA’s ability to provide uniformity.<sup>168</sup> Rather than a wholesale repeal of section 514, Congress could, alternatively, modify the Savings Clause<sup>169</sup> or the Deemer Clause<sup>170</sup> to

160. *But see* Zelinsky, *supra* note 17, at 460 (using the “race to the bottom” analogy). Zelinsky’s analysis is misguided insofar as he suggests that there is no need for federal legislation where there is no “race to the bottom” presently occurring. *Id.*

161. *See* Francesconi, *supra* note 17, at 236 (observing that federal legislation is a necessary means to health care reform).

162. *See id.* (acknowledging the regulatory gap that ERISA has created and federal laws have failed to fill).

163. *See* Preemption Clause, ERISA § 514, 29 U.S.C. § 1144 (1999) (stating that ERISA “shall supersede any and all state laws insofar as they may now or hereafter relate to any” employee welfare plan) (emphasis added).

164. Mental Health Parity Act of 1996, 29 U.S.C. § 1185a (1999); *see* Mental Health Parity Reauthorization Act of 2003, Pub. L. No. 108-197, 117 Stat. 2898 (extending the MHPA’s expiration date to December 31, 2004).

165. *See* Schacht, *supra* note 60, at 351 (arguing that re-writing ERISA to narrow preemption and provide for a certain baseline of coverage guaranteed by the federal government would promote the true spirit of the now-expired MHPA); *cf.* Zelinsky, *supra* note 17, at 470 (recommending that Congress amend section 514 of ERISA to allow states to protect patients’ rights rather than passing a federal “Patients’ Bill of Rights”).

166. *See* ERISA § 201(1), 29 U.S.C. § 1051(a)(1) (1999) (placing no substantive requirements, including vesting, on employee welfare plans).

167. ERISA § 514, 29 U.S.C. § 1144 (1999).

168. *See* Zelinsky, *supra* note 17, at 464 n.84 (acknowledging that there is “no reasonable prospect” for a repeal of section 514 of ERISA).

169. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) (1999).

170. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (1999).



include self-insured plans among the types of entities subject to state regulation.<sup>171</sup> This option would enable states to apply their parity laws to all health plans, including those that self-insure.<sup>172</sup>

For example, Congress could change the Savings Clause to read, “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates [health plans,] insurance, banking, or securities.”<sup>173</sup> Alternatively, Congress could delete the segment of the Deemer Clause that specifically excludes employee benefit plans from regulation as insurance companies.<sup>174</sup>

Amending the Deemer Clause would express clear congressional intent to empower the states to regulate even self-insured plans.<sup>175</sup> Assuming that each state already has laws in place regulating insurance, the proposed change to the Deemer Clause would simply apply these laws to self-insured plans. Changing the Savings Clause, however, would leave it up to each state to affirmatively choose to regulate self-insured employee welfare plans by passing new laws.<sup>176</sup> Unless a state takes the affirmative step of passing a law regulating health plans, there would be nothing for the Savings Clause to “save” from preemption.

Despite the support that it might receive from insurance companies,<sup>177</sup> such a modification of ERISA would meet staunch opposition from businesses that operate in multiple states and the members of Congress they support.<sup>178</sup> First, these changes would eliminate the interstate uniformity to which large employers have become accustomed.<sup>179</sup> Second, these changes would enable states to

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171. Cf. Zelinsky, *supra* note 17, at 448 (positing that Congress could increase the efficacy of state malpractice and HMO laws by enumerating those types of laws as exempt from preemption but leaving section 514 otherwise intact).

172. See Savings Clause, ERISA § 514(b)(2)(A) (saving from preemption certain, enumerated state laws).

173. See ERISA § 514(b)(2)(A) (exempting, at present, only insurance, banking, or securities entities from preemption).

174. See Deemer Clause, ERISA § 514(b)(2)(B) (stipulating that the Savings Clause does not currently apply to employee benefit plans).

175. See ERISA § 514(b)(2)(B) (providing the current formulation of the Deemer Clause).

176. See *supra* notes 172-73 (comparing the present version with proposed changes to the Savings Clause).

177. See Zelinsky, *supra* note 17, at 469 (explaining that federal mandates would reduce the attractiveness of self-insurance, reducing the customer attrition insurance companies are experiencing); see also discussion *infra* Part VII(C) (predicting that insurance companies might be unlikely advocates of federal parity legislation).

178. See ERISA § 2, 29 U.S.C. § 1001(a) (1999) (stating that the chief policy objective of ERISA's preemption clause was to maintain uniformity among the fifty states to minimize the administrative burden on large businesses that operate in several states).

179. See *Fort Halifax Packing Co.*, 482 U.S. at 10 (warning that a “patchwork

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tell big businesses how they should spend their money, never a popular move among fiscal conservatives.<sup>180</sup>

### *B. A Federal Parity Act*

Because it is highly unlikely that Congress would dismantle ERISA's preemption language,<sup>181</sup> the federal government should create a bare minimum of parity that would at least support each state's ability to decide for itself whether and how it wants to deal with the issue of parity.<sup>182</sup> Congress could do so by passing legislation, similar to the failed Health Insurance Reform Act,<sup>183</sup> that requires all plans to offer a bare minimum of mental healthcare.<sup>184</sup>

Determining what comprises the bare minimum and how to pay for it has been the topic of significant debate in Congress over the past few years.<sup>185</sup> While legislation representing substantial steps towards federally mandated parity has been proposed each session since at least 1995, each bill has failed due to concerns over the potential costs of mental health care.<sup>186</sup>

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scheme of regulation . . . would introduce considerable inefficiencies in benefit program operation").

180. See Jensen & Morrisey, *supra* note 11, at 9 (commenting that benefit mandates force employers to make spending cuts in other crucial areas that might curtail the growth and economic well-being of the company).

181. See The Wellstone Mental Health Equitable Treatment Act of 2003, S. 486, 108th Cong. (2003) (leaving preemption intact by stipulating that "nothing in . . . this Act shall be construed to affect or modify section 514 of the Employee Retirement Income Security Act of 1974"); see also Zelinsky, *supra* note 17, at 464 n.84 (advising against repeal of ERISA's preemption clause).

182. See Gregory, *supra* note 78, at 475 (noting that ERISA has created a "preemptive vacuum" that has robbed states of the power to protect the mental health of their citizens). But see Harrison, *supra* note 6, at 267 (noting that even federal parity legislation will not help the forty million Americans who have no health care coverage whatsoever).

183. S. 1028, 104th Cong. (1995).

184. See *id.* (attempting, unsuccessfully, to mandate coverage of mental health benefits for all those who have group medical or surgical benefits).

185. See, e.g., Mental Health Equitable Health Treatment Act of 2001, S. 543, 107th Cong. (2001) (requiring group health insurance plans to provide benefits for mental health services *totally equal* to those offered for medical and surgical services); Mental Health Equitable Treatment Act of 1999, S. 796, 106th Cong. (1999) (mirroring its successor); Mental Health Parity Act of 1996, 29 U.S.C. § 1185a (1999) (passing and requiring that plans providing mental healthcare cap the maximum amount of coverage at a level no lower than any cap placed on medical/surgical benefits); Health Insurance Reform Act, S. 1028, 104th Cong. (1995) (proposing the most comprehensive mental health coverage of any bill to date by placing an affirmative requirement on health insurers to offer mental health coverage).

186. See Mental Health Equitable Health Treatment Act of 2001, S. 543, 107th Cong. (2001) (surviving Committee but never receiving a Senate vote); see also Mental Health Equitable Treatment Act of 1999, S. 796, 106th Cong. (1999) (failing to progress beyond committee); see also The Health Insurance Reform Act, S. 1028, 104th Cong. (1995) (passing in the Senate but failing to survive the final conference committee due to significant opposition from business interests); see also 147 Cong.

Currently pending federal legislation, the Wellstone Act,<sup>187</sup> does not aim at full parity because it creates no affirmative requirement that health plans even cover mental health care.<sup>188</sup> In that regard, it is little more than a reauthorization of the recently expired MHPA of 1996.<sup>189</sup> Even though the Wellstone Act goes a step further than the MHPA by requiring coverage of all conditions listed in the *DSM-IV*, it remains a mere symbolic step in the right direction towards parity.<sup>190</sup> While it might lend much-needed credibility to more progressive state laws,<sup>191</sup> the Wellstone Act still would not guarantee the mental healthcare that children and adolescents need.<sup>192</sup> Because ERISA still preempts many state laws that require a greater degree of parity than the Wellstone Act, many companies could still skirt more demanding state laws by self-insuring.<sup>193</sup> Without simultaneous amendment of ERISA's preemption clause,<sup>194</sup> the Wellstone Act will be better than nothing but still not comprehensive enough to provide the parity that

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Rec. S11, 173 (daily ed. Oct 30, 2001) (statement of Sen. Domenici) (explaining that, insurance companies would foot "most" of the costs required by the Mental Health Equitable Treatment Act of 2001, but acknowledging "some" federal government responsibility); 147 Cong. Rec. S11, 173 (daily ed. Oct. 30, 2001) (statement of Sen. Wellstone) (accusing the insurance industries of attempting to kill the Mental Health Equitable Treatment Act of 2001 in committee); *see also* 147 Cong. Rec. S11, 180 (daily ed. Oct. 30, 2001) (statement of Sen. Gramm) (asking, "what about the twenty-three billion dollars of cost that [parity] will impose on the private sector? . . . what about the five billion dollars in tax revenue that will be lost when companies pay their employees lower wages in order to pay for this mandate?").

187. S. 486.

188. *See id.* (placing restrictions only on those health plans that currently offer mental health care by stating that "nothing in this section shall be construed as requiring a group health plan to provide coverage for specific mental health services").

189. *Compare id.*, with 29 U.S.C. § 1185a(e)(4) (enabling health plans to pick and choose which mental health ailments they will cover).

190. *But see* Satel & Humphreys, *supra* note 25, at 24 (stating that Congress should not mandate coverage of all conditions listed in the *DSM*, because many conditions listed therein are mere "signifiers of unhappiness, dissatisfaction, or troubling character traits").

191. *See* GAO MENTAL HEALTH PARITY ACT, *supra* note 64, at 9 (listing state laws with parity provisions more expansive than those in the Wellstone Act).

192. *See* Gregory, *supra* note 78, at 475 (urging legislation on the federal level, in light of the failure of state legislation to ensure minimum protections for mental health coverage).

193. *See* Schacht, *supra* note 60, at 305 (decrying the fact that the courts and Congress have created a loophole in ERISA that "enables self-insured employers to discriminate against those who need coverage most"); Nelson, *supra* note 17, at 100 (revealing that ERISA severely limits the number of individuals who actually benefit from state parity laws, even in those sixteen states that mandate full parity). *But see* Zelinsky, *supra* note 17, at 468 (noting that self-insurance simply is not an option for smaller employers who cannot afford to pay for their employees' medical bills).

194. ERISA § 514(a), 29 U.S.C. § 1144(a) (1999); *see supra* Part VII(A) (proposing amendment of ERISA's preemption clause).

America's teens need.<sup>195</sup>

Congress could improve the Wellstone Act by inserting the following requirements: mental health coverage for all those who have medical coverage; the same levels of co-payments, deductibles, and annual/lifetime caps for mental healthcare as for medical care; and dedicated funds to improve publicly-funded mental healthcare, which is currently little more than a neglected component of states' juvenile justice or social services systems.

Alternatively or additionally, Congress could improve the Wellstone Act by inserting a section amending ERISA's preemption provision.<sup>196</sup> As a last resort in the event that passage of the Wellstone Act seems unlikely, Congress could mandate "targeted parity."<sup>197</sup> This compromise position offers a bare minimum by covering only "catastrophic mental illnesses" but not every condition listed in the *DSM*.<sup>198</sup> Proponents of this position argue that it will serve those most in need of equitable benefits without creating threatening costs that might lead employers to drop their mental benefits entirely.<sup>199</sup>

### *C. Creating Vesting Provisions for Welfare Plans*

Thirdly, Congress might consider vesting provisions for employee welfare plans similar to those required of pension plans.<sup>200</sup> Over the past twenty years, Congress has given employees some security in their future healthcare benefits via the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")<sup>201</sup> and the Comprehensive Omnibus Budget Reconciliation Act of 1985 ("COBRA").<sup>202</sup> Vesting

195. See *supra* note 189 (demonstrating that the Wellstone Act is a mere reauthorization of existing legislation, rather than progress towards parity).

196. Cf. Zelinsky *supra* note 17, at 445 (calling amendment of ERISA's preemption clause a "plausible" means of avoiding a national Patient's Bill of Rights since such amendment would enable states to expand the scope of their regulatory power to include self-funded plans).

197. See Satel & Humphreys, *supra* note 25, at 24 (arguing that the mentally ill actually might benefit more if Congress was to scale-back the Wellstone Act to cover a selected category of illnesses).

198. See *id.* (recommending only coverage of "schizophrenia and other psychoses, autism, major depression, manic-depressive illnesses, and obsessive-compulsive disorder").

199. See *id.* (opining that the Wellstone Act is "so expansive [it] endanger[s] [its] own worthy mission").

200. See ERISA § 203(a), 29 U.S.C. § 1053(a) (1999) (requiring a pension plan to pay out to an employee all of the dollars that employee has contributed to a pension or retirement savings plan); Schacht, *supra* note 60, at 342 (describing support for such a proposal).

201. See HIPAA, 42 U.S.C.A. § 210 (West 2003) (amending ERISA to forbid insurance plans from rejecting a potential participant based on health status).

202. See COBRA, 29 U.S.C.A. § 1161 (West 2003) (providing plan participants and beneficiaries the option of continuing to pay for coverage under an employee welfare

provisions would go a step further and afford employees additional security by constricting an employer's ability to modify drastically or terminate a benefit plan at any time.<sup>203</sup> By adding vesting provisions for welfare plans, Congress could give employees an irrevocable interest in their health benefits, thereby reducing an employer's freedom to eliminate mental or other health benefit plans.<sup>204</sup>

However, providing employees with this level of security entails an enormous financial commitment on the part of employers.<sup>205</sup> ERISA's vesting provisions for pension plans require pension plans to maintain a certain level of funding to ensure that enough money will be available whenever participants reach retirement age.<sup>206</sup> If ERISA was to require the same of employee *welfare* plans, plans could become too costly for employers to maintain, and employer-sponsored health plans, as we know them, could come to an end.<sup>207</sup>

Federal legislators in favor of parity might find support in the health insurance industry for any of the three aforementioned

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plan even after the participant is no longer employed by the plan's sponsor).

203. See BLACK'S LAW DICTIONARY 747 (2d pocket ed. 2001) (defining "vested" as a "completed, consummated right for present or future enjoyment; not contingent; unconditional; absolute"); cf. ERISA § 203(a)(2)(B), 29 U.S.C. § 1053(a)(2)(B) (1999) (stipulating that employer pension contributions such as matching dollars vest in proportion to the amount of time an employee has worked at a company).

204. See John Thacher McNeil, *The Failure of Free Contract in the Context of Employer-Sponsored Retiree Welfare Benefits: Moving Toward a Solution*, 25 HARV. J. ON LEGIS. 213, 265-66 (recommending that Congress require all benefits to vest sometime before retirement in order to remove an employer's incentive to fire an employee just before retirement in an effort to avoid the benefit cost); Joseph Pereira, *Parting Shot: To Save on Health-Care Costs, Firms Fire Disabled Workers*, WALL ST. J., Jul. 14, 2003, at A1 (reporting that several companies have discontinued the health insurance plans of workers on disability leave); see, e.g., *UAW v. Yard-Man, Inc.*, 716 F.2d 1476, 1480-81 (6th Cir. 1983) (finding employer intent to vest welfare benefits in retirees, despite absence of specific vesting language).

205. See H.R. Rep. No. 807, 93d Cong., 2d Sess. (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4654 (reporting that Congress explicitly rejected vesting requirements for welfare plans because health insurance must respond to unstable variables such as inflation, changes in medical practice and technology, and increases in the cost of insurance). But see HEALTH, EDUC., AND HUMAN SERVICES DIV., U.S. GEN. ACCOUNTING OFFICE, EMPLOYER-BASED HEALTH PLANS: ISSUES, TRENDS, AND CHALLENGES POSED BY ERISA 44-48 (1995) (noting that many states already require welfare plans to hold a minimum amount of money in reserve). Self-insured plans, of course, skirt this requirement. *Id.*

206. See ERISA § 302(c)(3), 29 U.S.C. § 1082 (c)(3) (1999) (requiring minimum funding standards for pension plans based on actuarial assumptions and experience under the plan).

207. See *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1160 (3d Cir. 1990) (finding that Congress did not establish vesting requirements for employee welfare plans because it determined that vesting would "seriously complicate the administration and increase the cost of [welfare] plans"); McNeil, *supra* note 204, at 253 (reporting legislators' fears that creating vesting provisions for welfare benefits would hasten employer cancellation of such plans).

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options.<sup>208</sup> While insurers and health plan providers might have opposed parity in the past out of a fear of untrammelled costs,<sup>209</sup> they would probably support a bill that reduces the allure of self-insurance.<sup>210</sup> Because any of the aforementioned types of federal legislation could compel even self-funded plans to provide a mental health benefit, any could stem the flow of companies turning to self-insurance and help the health insurance industry retain customers and/or raise rates.<sup>211</sup>

## VIII. HOW STATES CAN ASPIRE TO PARITY

Recent Supreme Court decisions have enabled states to begin to exert more control over employee welfare plans.<sup>212</sup> In light of decisions such as *Rush Prudential HMO, Inc. v. Moran*,<sup>213</sup> states have renewed opportunity to assert their rights in the face of ERISA preemption, even without federal legislation supporting their efforts.<sup>214</sup> To offer mental health parity to their citizens, states should

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208. See Zelinsky, *supra* note 17, at 469 (explaining that federal mandates compel compliance from the top-down, regulating even self-insured plans and reducing the attractiveness of self-insurance).

209. See, e.g., Jensen & Morrissey, *supra* note 11, at ii (noting that coverage for a psychiatric stay can increase a plan's premium by thirteen percent). Coverage for visits to a psychologist can increase premiums by up to twelve percent. *Id.*; see also Harrison, *supra* note 6, at 269 (explaining and debunking the economic theory of "adverse selection" whereby those who need care the most would gravitate towards the plans that offer the most comprehensive mental health coverage, thereby driving up costs). But see GAO MENTAL HEALTH PARITY ACT, *supra* note 64, at 12-13 (noting that parity has not created costs as great as some once feared).

210. See Zelinsky, *supra* note 17, at 469 (noting that the option of self-insuring has led many companies to drop their insurance coverage once rates rise above a certain level). The risk of losing all of their customers to self-insurance has kept health insurance companies from price-gouging. *Id.*

211. See *id.* (underscoring the importance of preserving self-insurance as an option for companies who already pay exorbitant insurance premiums for their employees). But see Christopher Windham, *More Companies That Self-Insure Get Stuck with Huge Medical Bills*, WALL ST. J., Sept. 30, 2003, at B1 (noting that payment of insurance premiums does not always guarantee coverage of an employee). Even those companies that purchase insurance must shoulder the financial burden when insurance companies "laser," or drop, certain employees' coverage. *Id.* When an employee, who is typically very ill, is "lasered," her employer has the option of paying her healthcare bills, terminating her coverage, or firing her in order to avoid future expenses. *Id.*

212. See Windham, *supra* note 211, at B1 (claiming that recent decisions eliminate the need for federal legislation to fill the "regulatory gap").

213. 536 U.S. 355 (2002).

214. See *Rush Prudential HMO, Inc.*, 536 U.S. at 387 (declining to preempt an Illinois state statute regulating HMOs, even where that HMO might be part of a self-insured plan); see also E. Haavi Morreim, *ERISA Takes a Drubbing: Rush Prudential and Its Implications for Healthcare*, 38 TORT, TRIAL, & INS. PRAC. L.J. 933, 945 (2003) (suggesting three possible reasons for the Court's recent narrowing in its interpretation of ERISA preemption: 1) a social policy analysis favoring more expansive benefit provision; 2) a federalism analysis favoring states' rights; or 3) an

seize the moment to encourage parity by wording their legislation in a way that decreases the chances of preemption by ERISA.<sup>215</sup>

For instance, a state legislature might write a statute requiring independent review of a plan's decision to deny mental health benefits where that plan engages, in any way, the services of an insurer.<sup>216</sup> Such a statute would be "specifically directed at the insurance industry,"<sup>217</sup> thereby passing the "common-sense test."<sup>218</sup> It would also apply to those self-funded plans that hire insurance companies to provide HMO services, benefits administration, and stop-loss insurance.<sup>219</sup>

To survive preemption, such a statute should be able to fulfill at least two of the McCarran-Ferguson Act factors.<sup>220</sup> However, even a statute regulating all plans that engage the services of an insurance company would not be able to clear this hurdle.<sup>221</sup> Even though such a statute might be read to regulate "entities within the insurance industry," the services that benefits administration and claims processing companies provide are neither "an integral part of the relationship between the insured and the insurer" nor have the effect

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efficiency analysis favoring the elimination of the ERISA backlog in federal courts).

215. See *FERC v. Mississippi*, 456 U.S. 742, 788 (1982) (lauding the fact that the fifty states serve as "laboratories for the development of new social, economic, and political ideas").

216. Cf. ILL. COMP. STAT. ANN. 215 § 125/4-10 (West 2003) (giving participants the option of seeking independent medical review of HMO decisions whenever benefits are denied). Under this law, a HMO must provide the treatment if the independent reviewing physician determines that it is medically necessary. *Id.*

217. See *Pilot Life Ins. Co.*, 481 U.S. at 50 (finding that common-sense dictates that a regulation will not necessarily survive preemption analysis if it merely impacts the insurance industry but was not intended to regulate insurance).

218. See *Metropolitan Life Ins. Co.*, 471 U.S. at 740 (recommending that courts use a common-sense standard to determine whether a state statute "regulates insurance").

219. See *Third-Party Administrators* (reporting that most of the seventy percent of corporations in the U.S. who self-insure use third-party benefit administrators), at [http://www.managedcareinfo.com/third\\_party\\_administrator.htm](http://www.managedcareinfo.com/third_party_administrator.htm) (last visited Oct. 5, 2003) (on file with *Journal*). Compare *Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649, 653 (4th Cir. 1991) (holding that purchase of a stop-loss plan does not subject an employee welfare plan to state regulation), with *Michigan United Food & Commercial Workers Union v. Baerwaldt*, 767 F.2d 308, 313 (6th Cir. 1985) (subjecting a plan that purchased stop-loss insurance to Michigan state law).

220. See *Rush Prudential HMO, Inc.*, 536 U.S. at 356 (stating that a state law does not need to satisfy all three of the McCarran-Ferguson Act factors in order to survive the challenge of preemption).

221. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979) (interpreting the McCarran-Ferguson Act by creating three guideposts relevant to determining whether a practice is part of the "business of insurance"); see also *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (applying the *Royal Drug* guideposts in a refusal to recognize a health insurance company's peer review system as part of the "business of insurance").

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of “spread[ing] risk.”<sup>222</sup> Also, benefits administration is not a practice limited to entities within the insurance industry since many self-insured plans use pure-play, third-party administrators, or companies that provide claims processing services but not insurance.<sup>223</sup> Moreover, insurance companies would be able to circumvent such a law by spinning-off their benefits administration function into an entity totally separate from their insurance, reinsurance, and underwriting services.<sup>224</sup>

Those who lobby for parity on the state level, however, should be aware that national parity legislation might lead a few state legislators to withdraw their support of parity.<sup>225</sup> For too long, preemption has enabled an unknown number of state legislators to pay lip service to mental health parity without alienating their business constituents who fear that parity will increase their premium costs.<sup>226</sup> Unfortunately, but inevitably, some legislators will retract their support now that the laws they once voted for actually have “teeth.”<sup>227</sup>

## CONCLUSION

While those in favor of mental health parity for children and adolescents should continue to advocate an end to insurance discrimination on the state level, true equality will only be achieved if parity is mandated by the federal government.<sup>228</sup> By preempting state law, ERISA has all but nullified any progress states have made towards providing equal coverage of mental healthcare.<sup>229</sup> While there are

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222. See *Union Labor Life Ins. Co.*, 458 U.S. at 129 (using these three criteria to determine whether a given practice should survive preemption under the Savings Clause, ERISA § 514(b)(2)(a), 29 U.S.C. § 1144(b)(2)(A) (1999)).

223. See *Third-Party Administrators*, *supra* note 219 (reporting that over 350 pure-play third-party administration companies generate over eight billion dollars a year).

224. Cf. Cassell Bryan-Low, *Deals & Deal Makers: PriceWaterhouse’s Consulting Unit Files for an IPO*, WALL ST. J., May 3, 2002, at C5 (commenting on accounting firm PriceWaterhouseCoopers’s decision to spin-off its consulting business to circumvent the increased regulation and scrutiny accounting firms have received in recent years).

225. See *supra* Part VII (discussing the various options Congress has to support the states’ efforts at parity).

226. Cf. Julian E. Zelizer, *Seeds of Cynicism: The Struggle over Campaign Finance, 1956-1974*, 14 J. POL’Y HIST. 73, 86 (2002) (recognizing that legislators are usually eager to support issues that provide an illusory benefit for citizens as long as that support does not disrupt their relationships with the businesses who contribute to their campaigns).

227. See Jensen & Morrissey, *supra* note 11, at i (discussing the effect that state parity laws have had thus far).

228. See *supra* Part VIII (discussing whether and what types of federal legislation could close the regulatory gap left by ERISA preemption).

229. See *supra* Part V (describing the detrimental effects ERISA has had on efforts to end and/or remedy insurance discrimination against the mentally ill).



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several ways in which Congress could implement parity, the most likely to succeed is a bill similar to the Wellstone Act.<sup>230</sup> Even though the Wellstone Act<sup>231</sup> is not a panacea that will cure insurance discrimination and provide a remedy to victims of insurance discrimination, its passage will, at least, prevent the parity movement from taking a step backwards upon the recent expiration of the MHPA on December 31, 2004.<sup>232</sup>

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230. S. 486.

231. *Id.*

232. Mental Health Parity Act of 1996, 29 U.S.C. § 1185a (1999); see Mental Health Parity Reauthorization Act of 2003, Pub. L. 108-197, 117 Stat. 2898 (extending the MHPA's expiration date to December 31, 2004).