Parity Legislation Analysis

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Group health care plans have traditionally placed greater insurance limitations on mental health care services than they have on physical health care services. The primary reason for this has been a lack of demand for such services and a pervading view that mental disorders are different in nature than physical disorders.[1] This attitude is changing, and in the past fifteen years, various interest groups have been pressuring state and federal legislators to compel insurance companies to provide equal coverage for both forms of illness.[2] This initiative is known as "parity." It has and continues to generate wide debate among insurance providers, business groups, physicians, and insurance beneficiaries as they attempt to decide what constitutes a medical illness, what constitutes viable treatment, and what can and should be the available means to contain the rising costs of health care services.

Prior to the parity initiative, seeking mental health services was largely considered shameful, and mental disorders constituted a personal weakness and lack of willpower. Questioning an individual's mental health became a means of social control- a way to undermine a person's credibility and deal with undesirables. These people could be detained against their will without due process, and this practice was morally and legally justified in the name of protection.[3]

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[1] Maria A. Morrison, "Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation," *South Dakota Law Review* 45 (2000): 8.

[2] Michael J. Carroll, "The Mental Health Parity Act of 1996: Let it Sunset if Real Changes are not Made," *Drake Law Review* 52 (2004): 553.

[3] Thomas Szasz, "The Origin of Psychiatry: Coercion as Cure," in *The Medicalization of Everyday Life* (Syracuse: Syracuse University Press, 2007), 55–70.

Although stigma and involuntary commitment continue today, the attitude toward the mentally ill is shifting to a more compassionate relationship. As scientists conduct more studies to determine the link between the brain's structural and chemical processes and our thoughts and emotions, many people are increasingly accepting the claim that mental disorders, characterized by abnormal behavior are caused by abnormalities in the brain. Although science has yet to reveal what brain processes actually cause behavioral abnormalities, the societal belief that mental illnesses are rooted in brain processes drives the sentiment that mental illness and physical illness are no longer distinct.[4] As a result, people seek treatment for their mental disorders as well as a way to pay for them.

This paper will review the two successfully passed federal mental health parity laws as well as some of the parity legislation that has passed in various states. It will discuss the limitations of the Americans with Disabilities Act (ADA) to grant the relief that parity supporters demand, and it will discuss the concerns that opponents advance in the debate. Lastly, it will discuss the merits of the legislation and its ability to meet the needs of supporters, opponents, and the general public.

I. Legislative History: Federal and State Parity Laws

A. 1996 Mental Health Parity Act

In the mid-1990s Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) sponsored the Mental Health Parity Act (MHPA) in an effort to eliminate the differences between insurance coverage for mental and physical illness. For both senators, the former a conservative Republican from New Mexico and the latter a liberal Democrat from Minnesota, the parity issue was apparently of substantial personal interest. Both had family members

[4] Morrison, Maria A. op cit.

struggling from a diagnosed mental condition. Given the political affiliations of both men, the bill had substantial bipartisan support, and it sparked a larger debate in Congress about the proper role of insurance companies in mental health treatment, a topic that received scant public attention until then.

To illustrate the differences between insurance coverage for mental and physical illness, Senator Dominici listed some typical provisions imposed by health care plans. In his testimony before Congress he noted that insurance typically covers three hundred sixty five days of in-patient care for physical illness and limits coverage to forty five days for mental illness.[5] He also stated that where insurance plans cap lifetime expenditures for physical illness, the cap for mental illness expenditure is typically half that amount. Similar differences exist for out-patient care in over ninety percent of employer-sponsored plans. Despite these statistics, support for full parity waned as cost concerns entered the debate. While cost estimates varied greatly, Congress was concerned that mandating full parity would make some health plans prohibitively expensive for many people. As a result, Senators Domenici and Wellstone withdrew their original proposal in favor of more modest legislation.

Given the initial enthusiasm for full parity legislation, the final Mental Health Parity Act signed in 1996 accomplished relatively little in altering the insurance market. The Act modified both the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHSA). For the first time, federal law required equal aggregate lifetime and annual dollar limits between medical or surgical benefits and mental health benefits for large group health plans. The MHPA pertained to those insurance plans which offered some degree of coverage for mental health care, and two important exemptions. The first exemption applied to

[5] *Health Insurance Reform Act*, S 1028, 104th Cong., 2d sess., *Congressional Record* 142 (April 18, 1996): S 3591.

small employers with an average of between two and fifty employees. The second exemption applied to all group insurance plans if the cost of implementing the legislation would result in a cost increase of at least one percent.[6]

The marginal impact of the 2006 Mental Health Parity Act becomes clearer by examining what the legislation did not accomplish. The first large loophole evident from the text is the increased cost exemption. The text provides a formula for determining whether or not the group health plan qualifies by calculating the base period administrative costs and the expenses incurred as a result of the plan's compliance with the MHPA that would have otherwise been denied. The base period constitutes the first day that a plan begins to comply through the following six consecutive months.[7] Thus, exemptions cannot be determined on the basis of projected costs, but must follow the actual reported costs from the implementation period. If the plan does, after this time, qualify for the exemption, it is required to notify the plan's participants and provide, at no cost, the data upon which the judgment is based. Thirty days after the exemption is granted, the health plan is able to discontinue compliance for the remainder of the law's duration, even if provisions change in the future that may lower the costs associated with compliance.[8]

Given the limited scope of the MHPA and the substantial costs associated with qualifying for an exemption, it was used far less than lawmakers anticipated. The law affects only annual and lifetime caps on mental health expenditures, but it does not affect any caps on a per-treatment basis. Therefore, to avoid the complexities of legislation, most affected group health

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[6] *Mental Health Parity Act of 1996*, 29 U.S.C 1185a

[7] Ibid.

[8] Morrison, Maria A. op. cit

plans simply converted their existing dollar limits to specific inpatient and outpatient care limits that did not violate the MHPA.[9] Using actuarial tables, the conversion was simple and accurate, and it created no real cost increases to group health providers and no measurable change in the coverage for their clients.

In addition to those mentioned above, smaller limitations further affected the applicability of the Mental Health Parity Act to patients seeking mental health care. The law did not affect disparities in the cost of deductibles between mental and physical illness which, for many, made the cost of treatment too expensive. The MHPA also did not affect all health plans. It excluded plans offered by small employers and also plans that did not originally offer any mental health treatment coverage. Lastly, although the law covered mental health services, treatment for substance abuse was explicitly excluded. The supporters and sponsors of the 1996 Mental Health Parity Act were disappointed by the practical legislative effects, but they remained optimistic for further, more comprehensive legislation in the future. Passage of this bill created widespread public debate and generated calls for reform on both the federal and state levels.

B. State Parity Laws

Following the passage of the MHPA, many states began to treat the federal law as a minimum standard and to enact legislation imposing greater regulation on health care providers. Statutes vary widely from state to state, but they generally fall into one of four particular categories: broad parity laws, dollar minimum laws, day and visit limit laws, and biologically based or serious mental illness laws.

Broad parity laws are those which mandate complete parity between physical and mental illnesses rather than parity only for lifetime and annual maximum expenses. However, the

[9] Carroll, Michael J. op. cit.

structures of these laws also vary by state. Minnesota and Kentucky require broad parity but do not require any coverage for mental illness in health care plans which have traditionally excluded this coverage. Vermont, by contrast, not only mandates full parity but also requires that coverage for mental health services as well as substance abuse services be available under all health care plans.[10]

New Mexico enacted legislation very similar to that of Vermont but allowed for a possible cost exemption. In New Mexico, a plan may be exempt from the law if it experiences a premium increase of more than one and one half percent for small entities of fewer than fifty employees or if it experiences an increase of more than two and one half percent for entities of fifty employees or more. Furthermore, under this legislation, affected entities may either pay the increase, reach a cost-sharing agreement with employees, negotiate a coverage reduction to bring the increase just below one and one half percent or two and one half percent, or apply for affirmative exemption from the insurance division not to increase coverage.[11]

Other states such as Illinois and Louisiana, instead of mandating broad parity, mandate only that the option be available to employers who wish to provide that coverage to employees. In this case, insurers must offer a broad parity plan subject to the state's unique provisions, but employers are able to choose whether or not to buy such a plan based on the company's own cost calculations and employee preferences.[12]

Ohio and Wisconsin, rather than impose a full parity requirement, have instead mandated minimum amounts of coverage available annually for inpatient hospital visits and outpatient

[10] Ibid.

[11] NM Stat. Ann. §59A-23E-18

[12] Carroll, Michael J. op. cit.

services related to mental illness, nervous disorders, and substance abuse disorders. Initially, criticism appeared because minimum provisions were thought to violate the federal MHPA requirement to equalize annual coverage. However, the Wisconsin Commissioner of Insurance issued a bulletin on 28 April 1998 stating that such laws, in fact, do not violate federal law because insurance can be structured to comply both with the state mandated minimum and the federal equal maximum as long as the maximum coverage for physical illness does not fall below the mandated minimum for mental illness.[13] Although the spirit of the federal law that dollar limits not be imposed is violated by these states, no violation exists to the letter of the law, so these statutes have remained in effect.

Day and visit limit laws like those of Virginia, Colorado, and Hawaii require insurance providers to issue coverage for a certain number of days of inpatient visits and outpatient treatment for adults and children. However, the exact number of days varies by state. In Hawaii, insurance holders are allowed to convert coverage minimums if they need more coverage for inpatient care and less for outpatient care or vice versa.[14]

The most common state legislation on mental health coverage is called biologically-based mental illness or severe mental illness coverage. These laws can co-exist with the other forms of legislation mentioned above, but this form generally refers to the particular disorders which are covered by state law. Seven specific diagnoses are usually covered by biologically based mental illness laws including schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, schizo-affective disorder, and delusional disorder. This list is not exhaustive, and some states include many more while others include less. Although listing

[13] Carroll, Michael J. op. cit.

[14] Ibid.

which disorders are to be covered by insurance limits some of the uncertainties about how individual states define mental illness, discrepancies arise because some states defer to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the Internal Classification of Disease Manual (ICD), or the most recent federal provisions to make that determination. Furthermore, states also differ in the degree of mental impairment that must be present for a patient to receive coverage. Some do not specify, while others require, that the disorder be of sufficient severity to interfere with the life of the patient.[15] Although state mental illness laws have been praised by mental health advocates and providers for going beyond the minimal federal requirements, the differences in state legislation have provided additional stimulus for stronger and more comprehensive federal legislation.

C. 2008 Mental Health Parity and Addiction Equity Act

Despite the advocacy of parity supporters for more uniform and comprehensive legislation, parity laws on the federal level remained stagnant until 2008. The Mental Health Parity and Addiction Equity Act was attached as an amendment to the Emergency Economic Stabilization Act, and the political importance of the latter significantly reduced congressional debate of the former. The final text of the amendment was a compromise between differing House and Senate versions passed in 2007. Although these versions, S. 558 and H.R. 1424, were considered in their respective committees, the lack of comprehensive debate prior to the compromise and final ratification has lead some observers to characterize the outcome as both costly and ill-conceived.[16]

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[15] Ibid.

[16] Richard E. Vatz and Jeffery A. Schaler, "Through a Back Door Darkly: New Mental Health Insurance Requirements," *USA Today,* January 2009, 31.

Both the House and Senate parity bills expanded upon the 1996 version by including addiction and substance abuse disorders within the scope of mental disabilities requiring parity of insurance coverage. Both bills also closed the loophole created by the MPHA by prohibiting higher financial requirements, such as deductibles and copayments, and treatment limitations imposed on mental health care. However, H.R. 1424, sponsored by Representatives Jim Ramstad of Minnesota and Patrick Kennedy of Rhode Island, imposed significantly tighter requirements than S. 558, sponsored by Senators Ted Kennedy and Pete Dominici, in several areas.

One area of critical importance was the broad coverage mandate required in the House version but not in the Senate version. Previously defeated bills have attempted to tie coverage to the disease definitions of the DSM. Although H. R. 1424 does not impose this requirement directly, it does mandate that for any plan in which behavioral coverage is offered, the coverage must match exactly the requirements of the Federal Employee Health Benefit Program (FEHB). Because the FEHB plans are tied to the conditions listed in the DSM, the net result of the House parity legislation would be to recognize the DSM as the legal authority of mental health coverage requirements. No other diagnostic manual enjoys this much authority under the law, and the measure is potentially very costly because it removes the ability of employers to tailor their plans and allocate resources to best meet the needs of its particular group of employees.[17] By contrast, S. 558 as amended allows employees and states to retain the authority of defining what conditions will be covered, as many states have already chosen to do through biologically-based mental illness laws.

[17] House Committee on Education and Labor, *The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424)*, 110th Cong., 1st sess., 2007, 31-35.

Another discrepancy particularly relevant to the business community was the provision in H.R. 1424 that allowed states to intervene more substantially and to provide stricter requirements than federally mandated insurance coverage. In his testimony before the House Education and Labor Committee, Neil Trautwein, employee benefits policy counsel for the National Retail Federation (NRF), argued that the patchwork state requirements that may result from the passage of this bill would be potentially dangerous for the retail industry.[18] Because the vast majority of the companies represented by the NRF are located in many different states, imposition of stricter requirements in some states will prevent common benefits packages and affect retailers' ability to compete in the market. Although the NRF would prefer legislation requiring federal preemption of all state parity laws, Trautwein states that the compromise provision in S. 558 securing a narrowly-defined state preemption that applies only to fully insured and self-insured plans will be acceptable.

The final critical difference between the House and Senate parity bills is that the former lacks specific protection for medical management practices for self-insured plans. In his testimony before Congress, Jon Breyfogle of the American Benefits Counsel argued that medical management practices are critical to health care plans because they set standards for what constitutes effective and medically necessary care, thereby allowing plans to offer the most effective treatments with the lowest possible costs to their clients.[19] Although proponents of H.R. 1424 state that it is not their intention to prohibit management practices, the Counsel, its

[18] Ibid.

[19] House Committee on Education and Labor, *The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424)*, 110th Cong., 1st sess., 2007, 35-42.

members, and insurance companies prefer the language contained in the senate version which offers explicit protection in this area.

When two similar but non-identical bills are passed in each body of Congress, a compromise bill must be drafted and approved before the President may sign it. In March 2008, Senators Kennedy and Dominici wrote a compromise proposal which was then amended by House leaders to include more of the elements of the original House legislation. By August of that year, a final agreement was approved. In this bill, the common elements of both versions, such as parity of deductibles, co-payments, and treatment limits, were preserved. State parity laws will be preserved under the current standard, but the Department of Labor will annually audit state laws to judge whether or not they comply with the federal legislation. As the original Senate version proposed, plans will retain their medical management authority, but they will be required to provide patients with the terms of the medical necessity criteria and justification for any denials. However, the Government Accountability Office will now have the authority to review medical management practices that may be unusually restrictive. The clause in H.R. 1424 to use the DSM-IV to determine the scope of coverage was removed at the Senate's urging.

Lastly, exemptions similar to those available under the original 1996 MHPA were included in the 2008 parity law. These include an exemption for companies with fewer than fifty employees, an exemption for plans that do not offer any mental health coverage, and an increased cost exemption if expenses are greater than two percent in the first year or greater than one percent in subsequent years. Unlike the MHPA, however, the increased cost exemption

would only apply for the year that costs rise above the mandated threshold; companies would need to reapply in subsequent years if the costs of implementation remained elevated.[20]

Although the House and Senate reached a compromise on the language of the parity bill, funding and passing the bill on a common piece of legislation presented another difficulty. Congress estimated that the federal cost of the parity bill would be about $3.9 billion over a ten-year period based on estimates that employers would convert some taxable income to non-taxable health care benefits in order to comply with the new mandates. Despite several proposals, finding mutually-acceptable offsets in the federal budget became very difficult. The Senate attached the parity bill to the tax extender bill H.R. 6049. However, the bill was not entirely paid for, and the House refused to pass the bill in that form. In September, the House passed the parity bill as a stand alone bill called H.R. 6984 with funding through a corporate tax provision.

Although the parity language was identical to what had already been agreed upon, the Senate refused to ratify the stand alone bill because it would weaken pressure on the House to pass the tax extenders bill.[21] Congressional stalemate ensued until the Senate took decisive action. Parity legislation and the $3.9 billion funding problem were very small issues compared to the seven hundred billion dollar bailout initiative. When the House refused to pass the bailout initiative as a stand-alone bill, the Senate ratified the original house legislation H.R. 1424 striking all of the old language, adding the new parity compromise, and attaching the tax

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[20] *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, Public Law 110-343, 122 Stat. 3765 (2008).

[21] National Association of Addiction Professionals. 2009. *October 3, 2008: Mental health and addiction parity bill passes house; president expected to sign bill into law.* http://capwiz.com/naadac/issues/alert/?alertid=11436441 (accessed January 20, 2009)

extender bill and bailout package. Pressured politically to approve the bailout package, the House ratified the bill with all of the amendments on 3 October 2008. With President George Bush's signature, the small parity bill, to which everything else was attached, is now law.

II. Judicial History: Applicability of the Americans with Disabilities Act

Since the Americans with Disabilities Act (ADA) took effect in 1990, it has been the subject of substantial litigation with regard to its effects on the terms and availability of disability insurance plans. The final text was the product of negotiations between Congress, the insurance industry, and the disability community. However, many of the provisions were vague and somewhat contradictory leaving their scope and precise application to judicial interpretation. Titles I, II, III, and V have all been implicated in the debate, and, although plaintiffs have generally fared poorly in their discrimination claims, courts have preserved some narrow avenues for successful remedies.[22] This section will discuss the statutory language of the ADA, the interpretations of federal administrative agencies, and the resulting case law as it affects the insurance industry and the mental health community.

A. Statutory Language

Title I applies specifically to employment, and it states that a covered employer shall not "discriminate against a qualified person with a disability because of the disability of such individual in regard to job application procedures… and other terms, conditions, and privileges of employment."[23] The duty to prevent discrimination is extended to include contractual

[22] Mathis, Jennifer. 2004. The Bazelon Center for Mental Health Law. *The ADA's Application to Insurance Coverage*. http://www.bazelon.org/issues/disabilityrights/resources/insurance.htm (accessed February 8, 2009).

[23] *Americans with Disabilities Act*, 42 U.S.C. § 12112(a)

relationships between the employer and a third party which provides fringe benefits to the employees of the covered entity. Neither party may classify a disabled applicant or employee in such a way as to affect the status or opportunities of the disabled individual. Thus, Title I clearly applies to corporate insurance providers as third parties with a contractual relationship to the covered entity, but the extent to which they may disadvantage certain individuals on the basis of covered treatments is less exact.

Title II of the ADA applies only to state and local government entities and provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[24] Although most litigation arises from alleged Title I violations, Title II provides for redress of public employees in much the same way as Title I applies to the public sector.

Title III prevents discrimination by anyone who owns or operates a place of public accommodation and specifically references insurance offices as a covered location.[25] Under this section, discrimination arises from a denial of benefits to an individual on the basis of a disability or a privilege to some individuals that is not equal to the provisions available to other individuals. However, it is not clear from the text whether this section applies only to the availability of insurance policies or also to their specific provisions.

Title V of the ADA is known as the "safe harbor clause" because it limits the scope of the previous sections. Generally, it protects the right of insurance providers, health maintenance organizations, and medical service companies to underwrite risks based upon their classifications

[24] Id. § 12132

[25] Id. § 12182(a)

and actuarial calculations that are consistent with state law. However, the allowances of Title V "shall not be used as subterfuge to evade the purposes of subchapters I and III."[26] The subterfuge requirement has been the subject of substantial debate. The ADA does not clarify which practices are permitted as a result of legitimate risk calculation and which are prohibited as subterfuge existing to evade Titles I and III. Naturally, exclusions based on risk calculation are opposed to the equity goals of the previous sections, and courts have addressed this conflict in a variety of ways as will be discussed below in greater detail.

B. Federal Interpretation

The ADA Title III Technical Assistance Manual published by the Department of Justice attempts to clarify Congressional intent with respect to the requirements of Title III and the allowed derogations permitted under Title V.[27] It states that insurance companies, as places of public accommodation, are prohibited from discriminating in the sale or in the terms and conditions of their insurance contracts. However, because the insurance business is dependant upon risk calculations, the company's consideration of a disability in the sale of an insurance contract does not always rise to the level of discrimination.[28] For example, a public accommodation may offer a plan that limits certain kinds of coverage available to the insured individual on the basis of its risk calculation. A plan may not refuse, limit, or differentiate available coverage unless such actions are based on specific actuarial principles or reasonably anticipated costs. It is interesting to note, however, that although the ADA permits differentiation

[26] Id. § 12201(c)

[27] United States Department of Justice. *ADA Title III Technical Assistance Manual Covering Public Accommodations and Commercial Facilities.* http://www.ada.gov/taman3.html (accessed February 14, 2009).

[28] Ibid.

with justification in insurance-related matters, it does not require companies to provide the actuarial calculations on which their judgments are based.

The Equal Employment Opportunity Commission (EEOC) further clarifies the permissible insurance differentials. It states that a disability-based insurance distinction must be covered under the safe harbor provision of Title V in order not to be held in violation.[29] Insurance distinctions that are not disability-based and those that are applied equally to all insured employees within the covered entity do not violate the ADA, regardless of whether or not the safe harbor provision applies. Disability-based distinctions are those that reference a specific disability such as AIDS or schizophrenia or reference a discrete group of diseases such as cancers or heart diseases for which lesser benefits are provided.

However, the agency notes that not all health-related distinctions are considered disability-based distinctions. Mental and nervous conditions, which have historically been subject to lower levels of insurance coverage than physical illness, are one such example. The Interim Enforcement Guidance states "such broad distinctions, which apply to the multitude of dissimilar conditions and which constrain individuals with and without disabilities, are not distinctions based on disability."[30] Based on this reasoning by the EEOC, it appears that the courts would have ample justification for denying mental disability discrimination claims alleging a violation of the ADA.

C. Case Law

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[29] United States Equal Employment Opportunity Commission. *EEOC Interim Enforcement Guidance on the Application of the ADA to Disability-Based Provisions of Employer-Provided Health Insurance*. http://www.eeoc.gov/policy/docs/health.html (accessed February 14, 2009).

[30] Ibid.

Courts have used several different justifications for denying mental disability insurance claims under the ADA. In *Parker v. Metropolitan Life Insurance Company* (1997), the plaintiff brought suit alleging that an employer's long-term disability plan that covers physical disabilities until age sixty-five and mental and nervous disabilities for twenty-four months violated Titles I and III. The Sixth Circuit failed to uphold the Title I claim stating that Title I protects only qualified employees with a disability. Parker had been suffering from severe depression and collecting disability benefits under her employer-provided plan, but after twenty-four months, the payments expired and Parker did not return to work. Because Parker's long-term disability prevented her from performing the essential functions of her job, she was no longer "qualified" with respect to Title I.[31] By the court's reasoning, Parker had no available remedy. The nature of her disability prevented her from being qualified to work under the law.

The court also rejected her Title III claim stating that Title III regulates only the availability of goods and services offered by a public accommodation, but it does not regulate its contents. The court recognized that an insurance office was a place of public accommodation as set forth in the legislation, but the products offered by the insurance company are not. For redress under Title III, there must be a nexus between the place of public accommodation and the user. In this case the nexus did not exist because the disability plan was offered by the employer rather to the general public by the insurance office.[32]

Another critical case was *Ford v. Schering-Plough Corporation* (1998). Under circumstances similar to those discussed in *Parker,* plaintiff brought suit against her employer and insurance policy carrier alleging that the plan's provisions which covered physical

[31] *Parker v. Metropolitan Life Insurance Company*, 121 F.3d 1006 (6th Cir. 1997)

[32] *Parker,* 121 F.3d at 1010 (6th Cir. 1997)

disabilities until age sixty-five but mental disabilities for only two years violated the ADA. However, unlike the Sixth Circuit, the Third Circuit in this case held that the plaintiff did have standing under Title I. The Court reasoned that these disabled individuals need some legal recourse in the event of possible employment discrimination. However, the court did not find that discrimination occurred in this case. The ADA does not require equal coverage for every type of disability, and, because the same terms were available to all employees equally, the plaintiff was not discriminated against on the basis of her disability.[33]

Ford, like *Parker*, also included a Title III claim. Following the same line of reasoning, the Third Circuit held that the terms and conditions of the plan are governed only by Title I and that the terms of the plan did not constitute a place of public accommodation. Because the plaintiff received coverage under the plan through her employer, she lacked a sufficient nexus to the insurer to have suffered discrimination by the place of public accommodation.[34]

Lewis v. Aetna Life Insurance Company (1997) offers yet another departure from previous reasoning. In this case, Lewis, an employee of Kmart, sued his employer and insurance provider after collecting disability benefits for depression which left him unable to work. His mental health benefits were terminated after two years, but, under the plan, physical disability benefits are available until age sixty-five. He alleged that this plan's differential treatment of people with disabilities violated the terms of the ADA. The United States District Court for the Eastern District of Virginia agreed stating that such plans do violate ADA unless the distinctions are justified by actuarial calculations. Such calculations must prove that plans which discriminate

[33] *Ford v. Schering-Plough Corporation,* 145 F.3d 601 (3rd Cir. 1998)

[34] *Ford,* 145 F.3d 601 (3rd Cir. 1998)

against mental disabilities are less expensive than those that do not.[35] As a practical matter, it is obvious that paying for a disability benefits is necessarily more expensive than not paying for it. Nevertheless, having not conducted a formal cost analysis, the court found in favor of Lewis, and Kmart was ordered to pay his disability benefits until Lewis reached age sixty-five. The case against Aetna was dismissed on the grounds that the statute of limitations had already expired.

Many hoped that *Lewis* represented the first breakthrough in judicial ADA interpretation for the mentally ill.[36] However, Kmart appealed to the Forth Circuit, and, following the rulings in *Parker* and *Ford,* the court held that the ADA did not prohibit long-term disability plans from offering different terms for mental and physical disabilities.[37] All three cases noted that not only was this interpretation correct given the statutory language, it was also clear from the enactment of the 1996 MHPA. Had Congress intended the ADA to mandate parity between categories of disabilities, they would not have needed additional parity legislation governing insurance contracts.

III. Opposition to Parity Legislation

A. Cost Concerns

Arguments against parity legislation frequently focus on the increased cost of providing a level of mental health care equal to that of physical health care. Opponents are afraid that substantial increases in the cost of health plans will be passed to individuals, some of whom may not be able to afford their insurance policies at the new price. Additionally, opponents are

[35] *Lewis v. Aetna Life Insurance Company*, 983 F. Supp. 1158 (E.D. Va. 1997)

[36] Morrison, Maria A. op cit..

[37] *Lewis v. Kmart Corporation,* 180 F.3d 166 (4th Cir.)

concerned that the increased costs of mental health care could be offset with decreases in coverage for physical illness without violating parity legislation. Both federal parity laws have been reduced in scope to address these concerns. As a result, parity supporters have sought numerous studies to prove that financial consequences of full parity legislation will be minimal.

Original cost estimates varied widely prior to the enactment of the 1996 MPHA with supporters arguing that increases would be low and business groups and insurance companies arguing that increases would be high.[38] However, more recent findings overwhelmingly suggest that the costs of parity were not as high as the opponents predicted. Several more recent studies show that parity laws have modest cost increases for both full parity laws and more moderate proposals. These studies are based on the actuarial calculations for the most recent 2008 federal parity legislation and measured impacts of many of the state-level full parity laws currently in effect. Other studies show that providing mental health care actually decreases employer costs through increased productivity and less expenditure for physical illness that proceeds from a mental or emotional disturbance.

Because the 2008 MHPAEA does not take effect until next year, comprehensive studies on its cost effects are not yet available. However, to predict the likely rate increases necessary to comply with the legislation, Capital Decisions Incorporated contracted the actuary firm Millman Incorporated to conduct a study. Testifying before the House Subcommittee of Health, Employment, Labor, and Pensions, Steve Melek, a Millman actuary, discussed the company's

[38] See, e.g., Watson Wyatt Worldwide. 2006. The Costs of Uniform Plan Provisions for Medical and Mental Health Services: An Analysis of S. 298, the 'Equitable Health Care for Severe Mental Illness Act.' Bethesda, MD: Watson Wyatt Worldwide. (estimating an 11.4 percent cost increase for parity legislation applicable to serious mental illness only) and Rodgers, Jack. 1996. Analysis of the Mental Health Parity Provision in S.1028. Washington, DC: Price Waterhouse LLP. (estimating an 8.7 percent cost increase for the 1996 MPHA).

findings. He states that the findings indicate only a modest cost increase relative to current premium rates and the ongoing annual inflation in the health care industry.[39] Millman predicts an average increase of .6 percent, about $2.40 per member per month, in their baseline scenario. The baseline scenario assumes that employers and insurance companies will take no additional steps to compensate for the increased costs and pass them directly onto policy holders. Additional studies from the Congressional Budget Office indicates that this rarely occurs in practice. Typically, both parties try to mitigate the cost effects by reducing benefits and by increasing employee premium contributions so that approximately sixty percent of the cost is offset. Applying these finding to their baseline estimate, Millman predicts that the real cost increase will be only about .2 percent.

In another scenario considered by Millman, the cost increase could be even lower. The 2008 legislation does not prohibit utilization management whereby insurance companies tightly evaluate the appropriateness and medical necessity of particular treatments. Therefore, it may be reliably anticipated that some health care plans will increase their utilization management practices providing additional cost offsets and allowing for only a .1 percent premium increase, about three cents per person per month.[40] Under the increased utilization management scenario, Millman predicts that the use of facility based behavioral healthcare services would decrease by 21.3 percent while the use of professional services would increase by 3.1 percent. Under the baseline scenario, utilization would increase by 9.7 and thirty percent respectively.

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[39] House Committee on Education and Labor, *The Paul Wellstone Mental Health and Addiction Equity Act of 2007 (H.R. 1424)*, 110th Cong., 1st sess., 2007, 42-54.

[40] Ibid.

The Millman study represents only projected costs of the 2008 parity legislation, but the findings seem reliable given some of the prior studies on state parity costs. In a 1998 study by the Substance Abuse and Mental Health Services Administration (SAMHSA), the costs of parity were examined through case study analysis.[41] The researchers contacted forty seven organizations including insurance companies, employers, employer associations, and public officials, such as representatives from the state departments of mental health and substance abuse. All of these organizations were located in Maryland, Minnesota, New Hampshire, Rhode Island, or Texas. These states were selected because they all had laws requiring parity in either the public or private sector for at least one year.

Based on the information provided by informants, the SAMHSA study concluded that health care premium increases were generally very small. Costs in Maryland, Minnesota, and Rhode Island were all estimated to be less than two percent while companies in New Hampshire estimated the cost increase at less than five percent. Texas, the only state to mandate parity for public employers, had a unique effect. Premiums decreased by about 1.5 percent most likely because at the time parity was implemented, the fee-for-service plans were replaced by managed care plans.[42] Previously, very high costs for mental health and substance abuse services were dramatically decreased as managed care cut many of the previously available services through utilization management. This shift saved insurance companies substantial amounts of money despite the parity requirement. However, in addition to the increased use of managed care, the study found that costs of parity legislation were also modest because the laws did not affect very

[41] Sing, Merrile et. al., Substance Abuse and Mental Health Services Administration. *The costs and effects of parity for mental health and substance abuse insurance benefits.* Washington, D.C.: DHHS, 1998

[42] Ibid.

many people. In New Hampshire, for example, the parity mandate was restricted to apply only to the severely mentally ill. Not only is the population of severely mentally ill very small, an even smaller portion of that population is employed by companies with comprehensive health plans.

In addition to case study data, SAMHSA used actuarial data to estimate the cost increases under full parity conditions. Their model predicted that full parity will raise family premiums by 3.6 percent in a composite of plans. A composite of plans means a weighted average of fee-for-service (FFS), preferred provider organization (PPO), point-of-service (POS), and health maintenance organization (HMO) plans. The FFS and PPO plans would incur about a five percent increase while more tightly managed plans like HMOs would incur only a .6 percent increase.[43] Therefore the differences in costs between different plans are severe, and insurance companies generally have much to save by switching formats. Accordingly, the study affirms earlier conclusions that in order to contain costs, most companies switch to managed care plans rather than becoming self-insured or dropping mental health care altogether.[44]

Not only have studies concluded that parity legislation presents minimal cost increases for employers and insured individuals, some studies conclude that parity may produce an overall reduction in health care expenses. There are essentially two ways in which this can occur. In the first case, parity may reduce costs because it prompts a shift toward managed care as in Texas example mentioned above. In the second case, providing basic mental health services at low cost to employees may lower their incidence of physical illness and disability claims and increase

[43] Ibid.

[44] See e.g. National Advisory Mental Health Council. *Parity in Coverage of Mental Health Services in an Era of Managed Care: An Interim Report to Congress.* Rockville, MD: National Institute of Mental Health, 1999

their productivity. The second claim is more controversial and difficult to quantify, but some preliminary statistical analysis exists to support each side of the debate.

The National Advisory Mental Health Council highlights some of the most prominent studies in support of the cost reduction hypothesis. They state that the World Health Organization has linked substantial physical disability to incidence of mental illness, particularly major depressive disorder.[45] Among those able to work, the authors cite dramatic reductions in their work productivity and ability to handle stress in the workplace. Many simple treatments for depression, including medication and cognitive therapy, increase productivity, satisfaction, and work relations. Another study mentioned by the organization examines the impact of mental disorders on short-term disability claims.[46] It concludes that short-term disability claims are much higher among the population of mentally ill, particularly those with major depressive disorder. Prevalence of disability among the depressed group ranged from thirty seven to forty eight percent compared with the control population of seventeen to twenty one percent. Those with major depressive disorder also missed between 1.5 and 3.2 more days of work than the control group.

Several factors may call into question the relevance of the above studies and their impact on cost reductions. First, the diagnosis of a mental disorder is highly subjective. The severity of behaviors that lead to the diagnosis of major depression vary by psychologist and also by patient. Second, the studies above are correlation studies. It is not clear from the procedure which type of illness was responsible for the other or whether the correlation is influenced by another,

[45] Kirschstein, Ruth L. National Advisory Mental Health Counsel. *Insurance Parity for Mental Health: Cost Access and Quality: A final Report to Congress by the National Advisory Mental Health Counsel.* Bethesda: NIH, 2000.

[46] Ibid.

unobserved factor.. Third, other studies such as SAMHSA conclude that there is no observable link between mental illness coverage and increased employee productivity. The SAMHSA study is particularly relevant because their findings relied on reports from employers. Although most did not study the impact empirically, those that did reported no change.[47]

B. Disease Classification

Other concerns about mental health parity arise from the prospective that mental illnesses are not diseases as advocates and many mental health professionals claim. The term mental illness is instead a disease metaphor that has become integrated into medical culture and mistaken for literal disease.[48] Diseases are known in pathology as lesions or cellular abnormalities such as a cancer or bacterial infections. Their signs are physical and empirical, and they affect part of the body. Mental illnesses, by contrast are not part of this category. To be sure, mental illness is decidedly absent from standard pathology textbooks. All mental illnesses are characterized by behaviors rather than physical damage to the brain or any other bodily structure. In this way mental illnesses are not diseases but rather social problems of living best explained by personal values and the ability to cope with environmental circumstances.[49]

Critics of this perspective argue that although the strict, pathological disease definition is correct, it is also dehumanized. The mind and brain are not synonymous terms. A structural change in the brain is likely to produce a cognitive change in the mind reflected in thoughts and

[47] Sing, Merrile et. al. op. cit.

[48] Thomas Szasz, "Mental Illness: A Metaphorical Disease," in *The Medicalization of Everyday Life* (Syracuse: Syracuse University Press, 2007), 3–9.

[49] Vatz, Richard E. and Jeffrey A. Schaler. op.cit.

behaviors.[50] Because the brain is a very complex organ which scientists know comparatively little about, it may be the case that scientists in the future discover a physiological link between the behaviors that characterize mental illness and abnormalities in brain structure.

However, Szasz responds that once we determine a physiological basis for a mental illness, it ceases to be characterized as a mental illness.[51] This was the case with syphilis in the early 1900s when scientists discovered that the hysteria associated with the disease was caused by a bacterium. Furthermore, Szasz shows that dehumanization of mental illness patients is often used as a criticism against his arguments. This is not a claim that invalidates or refutes the argument, but rather a claim that appeals to sympathy.[52] Whether or not it is more humane to argue against human agency is an irresolvable question. It is also indicative of a fundamental difference in values.

Opponents also claim that this position represents psychiatric abolitionism, but this is not entirely accurate. While the perspective does not acknowledge that mental illnesses are diseases, it does respect the right of individuals to use their resources to seek help with problems of living if they desire such help. A problem with parity legislation is that it further legitimizes the claim that mental illnesses and brain diseases are equivalent. This presents three further problems for parity legislation: (1) reducing the stigma for mental illnesses removes a social disincentive for destructive behavior; (2) self-help programs for mental disorders, especially addictive disorders,

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[50] E. James Lieberman, "Pharmacracy or Phantom?" in *Szasz Under Fire,* ed. Jeffrey A. Schaler (Chicago: Open Court, 2004), 225–41.

[51] Szasz, Thomas. op. cit.

[52] Thomas Szasz, "Reply to Lieberman," in *Szasz Under Fire,* ed Jeffrey A. Schaler (Chicago: Open Court, 2004), 242–51.

are free and require no financial subsidy; and (3) what is considered a mental disorder may constitute an entirely reasonable reaction to a traumatic circumstance.

Supporters of parity legislation often cite past discrimination of the mentally ill and emphasize the need to reduce the social stigma of these disorders. Supporters believe that these behaviors are entirely outside the control of the patient, and, as such, he should not be held accountable for his actions. Opponents take the opposite view. Although behavior may be difficult to control, all behaviors are modes of conduct directed by intent and are therefore controllable through an exercise of free will.[53] By reducing the social stigma, the pressure to conform to the behavioral norms of society erodes. Erosion of the social control mechanism enables individuals, either innocently or strategically, to seek special exemptions and privileges available to the legitimately disabled. Stated another way, parity legislation induces the same moral hazard endemic to other forms of insurance. People are more likely to act recklessly when the costs of their behavior are shared by other entities.

Although the reasoning above follows chiefly from logic, there is some statistical analysis to support this claim. A paper published in the *University of Chicago Journal of Legal Studies* examined the relationship between state parity legislation covering substance abuse and the frequency of consumption of addictive substances.[54] To test this relationship the authors examined alcohol consumption levels in states with substance abuse parity laws before and after the parity legislation was adopted. These levels were compared to contemporaneous changes in alcohol consumption in states that did not adopt parity legislation. To control for possible

[53] Vatz, Richard E. and Jeffrey A. Schaler. op.cit.

[54] Jonathan Klick and Thomas Strattman, "Subsidizing Addiction: Do State Health Insurance Mandates Increase Alcohol Consumption?," *University of Chicago Journal of Legal Studies* 35 (2006): 175.

endogenous and undetected variables, the authors conducted an instrumental variables analysis. With the control in place, they determined that there was a statistically significant rise in alcohol consumption in parity states. This conclusion supports the authors' hypothesis of the "rational addiction model" which assumes that people act rationally to a change in incentives.[55] From a public policy perspective, their findings indicate that parity laws have unintended consequences as theorized by economists and parity opponents.

The second problem with parity legislation according to opponents is that much of the treatment available for mental illness, and substance abuse in particular, is not medical in nature and can be obtained free of charge. Addictive disorders are frequently treated with religion and meditation. Alcoholics Anonymous, a free, faith-based treatment program, is just as effective as the best treatment that contemporary psychology has to offer.[56] Additionally, success and recidivism rates for both forms of treatment are similar to corresponding measures for people without formal treatment. If mental health treatment cannot demonstrate success rates higher than those for free treatment or no treatment, there is little evidence to conclude that it is medically necessary. If treatment is not medically necessary for addictive disorders, there is no reason for the government to require insurance companies to provide financial assistance for individuals seeking these programs.

The third issue for parity opponents is that many of the individuals labeled mentally ill are reacting to traumatic life circumstances. While their behaviors may be unusual for the individual or unusual in the general population, they may be an entirely rational reaction to their

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[55] Ibid.

[56] Project MATCH Research Group. "Project MATCH: Rationale and Methods for a Multisite Clinical Trial Matching Patients to Alcoholism Treatment," *Alcoholism: Clinical and Experimental Research* 17 (1993): 1130.

environmental circumstances.[57] Such individuals may include military veterans returning from war, a population which has gained media attention as returning soldiers have experienced trouble readjusting to civilian life. Other individuals may include parents who are grieving from the loss of a child or a physically ill patient in chronic pain. In each case, environmental factors are sufficiently severe to justify unusual levels of stress or sadness. It may be helpful for people experiencing these adverse life events to speak to a counselor and engage in cognitive therapy, but they are not sick in medical terms. For people who are not experiencing a medical problem, health insurance is an inappropriate mechanism for granting relief.

Conclusion:

In order to properly evaluate legislation, two questions must be answered: (1) is the intended purpose of the legislation objectively desirable, and (2) does the legislation effectively achieve its intended purpose. At present, the answer to both questions is somewhat ambiguous. The trajectory of incremental measures and public opinion appear to be answering both in the affirmative.

As discussed above, parity legislation gained support as the demand for services increased. People have largely accepted, correctly or not, that mental illness likely has a physiological basis and, as such, should be treated as a medical condition. Opinions differ on this point, but neither federal nor state legislation prohibits the sale of health insurance plans which completely exclude mental illness coverage allowing for opponents to select a different form of coverage.

[57] Vatz, Richard E. and Jeffrey A. Schaler. op.cit.

It is necessary that any parity legislation be cost-conscious to achieve public confidence and support. Because of the increase in managed care practices, costs of services have been effectively contained, and in some cases expenses have decreased. Parity legislation is also considered objectively desirable because it is the only mechanism whereby insured individuals may receive benefits. Although the Americans with Disabilities Act has been used as a vehicle for mental health insurance in a number of cases, it has been largely ineffective in granting the financial relief that patients sought.

To evaluate the second question, few would contend that the federal parity legislation currently in effect is ideal. Supporters advocate for a higher degree of coverage that eliminates exceptions and restricts the use of managed care practices to prohibit exclusion of certain benefits. Certainly the 1996 Mental Health Parity Act, by providing only for equal lifetime and annual dollar limitations, did little to enhance access to mental health services. However, the 2008 legislation reaches much further, closing many previously available loopholes in a cost-effective manner. Perhaps future parity laws will mandate a greater degree of coverage, but this incremental progress is endemic to the legislative process.

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