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Legislative "Subterfuge"?: Failing to Insure Persons with Mental Illness under the Mental Health Parity Act and the Americans with Disabilities Act

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Legislative “Subterfuge”?: Failing to Insure Persons with Mental Illness Under The Mental Health Parity Act and the Americans with Disabilities Act

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I. INTRODUCTION

The two primary problems with providing health care in the United States are cost and access.¹ The cost of health care rose dramatically during the 1970s and 1980s² and continues to increase,³ making cost containment crucial to the availability of care.⁴ In addition, many Americans are either entirely without health insurance⁵ or are underinsured for catastrophic illness.⁶ While individually these two issues are important, equally problematic is

1. Jeffrey Rubin, *Paying for Care: Legal Developments in the Financing of Mental Health Services*, 28 *Houston L. Rev.* 143, 146 (1991) (citations omitted). A third issue is the need to ensure the quality of health services, especially considering the need to cut costs simultaneously. Often, attempts to improve quality can raise cost concerns, resulting in a trade-off between the two. As the health care industry shifts increasingly toward managed care, such quality-cost tradeoffs are of increasing occurrence and concern. James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 *Cornell L. Rev.* 1459, 1466 (1994). In the area of mental health, the issue of quality may be even more contentious than in the remainder of the health care industry, because the proper treatment of mental illnesses can be highly elusive and cause debate even within the mental health community. See John Petrila, *Ethics, Money, and the Problem of Coercion in Managed Behavioral Health Care*, 40 *St. Louis U. L. J.* 359, 391 (1996) (noting that "little apparent consensus" exists regarding the standards for treatment and outcomes in mental health care).

2. Daniel Y. Patterson and Steven S. Sharfstein, *The Future of Mental Health Care*, in Judith L. Feldman and Richard J. Fitzpatrick, eds., *Managed Mental Health Care* 335, 336 (American Psychiatric Press, 1992).

3. See *Moderate Rise in Employer Health Costs Not Likely to Last, Foster Higgins Says*, 5 *Health Care Policy Rep. (BNA)* 158 (Jan. 27, 1997) (reporting a 2.5% increase in employer health costs during 1996 and forecasting greater increases in the near future).

4. See David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 *Harv. C.R.-C.L. L. Rev.* 49, 49 (1996) (arguing that unless the growth in the amount of resources devoted to health care is checked, useful and necessary medical care will become unaffordable).

5. A recent study estimated that 40.3 million people in the United States are uninsured. *Uninsured Population Increased to 40.3 Million in 1995, EBRI Says*, 4 *Health Care Policy Rep. (BNA)* 1737 (Nov. 4, 1996). This figure represented a rise from 39.4 million in 1994. *Id.*

6. See generally Pamela F. Short and Jessica S. Banthin, *New Estimates of the Underinsured Younger Than 65 Years*, 274 *JAMA* 1302 (1995). According to Short and Banthin, 18.5% of the population below the age of sixty-five were projected to be underinsured by their private insurance for catastrophic illness in 1994. *Id.* at 1304. An individual was defined as "underinsured" if she was at risk of out-of-pocket expenses exceeding 10% of her family income in the event of a severe illness that has a one-in-one-hundred chance of occurring. *Id.* at 1302. Including the uninsured, the authors concluded that one-third of those under age sixty-five are inadequately insured in any given year. *Id.* at 1305.

the tension that exists between them. Providing greater access to additional services results either in a cost increase or the loss of other services.⁷ Ultimately, however, a general plan to contain costs can address the two issues simultaneously because the ability to contain costs can create greater access.⁸

The issues of access and cost are particularly pronounced in insurance for mental health services.⁹ For those Americans with private insurance, most coverage is provided by employer-sponsored health plans.¹⁰ In these plans, mental health care is possibly the most common target of coverage limitations on services and illnesses.¹¹ These limitations cap benefits for mental health care¹² at far lower levels than those for traditional medical and surgical care.¹³ Both the

7. See Orentlicher, 31 Harv. C.R.-C.L. L. Rev. at 50 (cited in note 4) (noting that health care sources can be rationed either by cost or by devoting fewer resources to various categories of illnesses and patients). Examples of this effect are obvious. Suppose a health plan does not include mental health services. If these services are added without a corresponding decrease in access to another service, the overall costs of the plan will increase, unless the insured do not actually use the mental health services.

8. See Petril, 40 St. Louis U. L. J. at 368 n.20 (cited in note 1) (noting that "there are reports that cost containment and increased access to appropriate services are not mutually exclusive").

9. See M. Susan Ridgely and Howard H. Goldman, *Putting the Failure of National Health Care Reform in Perspective: Mental Health Benefits and the "Benefit" of Incrementalism*, 40 St. Louis U. L. J. 407, 416-17 (1996) (discussing access problems peculiar to the mentally ill that are heightened when policy efforts are focused on cost containment). Moreover, the mentally ill are generally poor and less insured, and their disorders often impair their ability to advocate and seek care for themselves. *Id.* One study estimated that, in 1994, 17.1% of the privately insured were underinsured for inpatient mental health care, while 34.1% were underinsured for outpatient care. Short and Bantim, 274 JAMA at 1304 tbl. 2 (cited in note 6). These estimates were based on the percentage of those whose insurance provided for thirty days or less of inpatient care and thirty or less outpatient visits. *Id.*

10. Thomas G. McGuire, *Predicting the Cost of Mental Health Benefits*, 72 Milbank Q. 3, 4 (1994). More specifically, studies have estimated that 64% of Americans receive some kind of employer-sponsored coverage. Richard G. Frank and Thomas G. McGuire, *Mandating Employer Coverage of Mental Health Care*, 9 Health Affairs 31, 32 (Spring 1990) (footnote omitted). According to labor statistics from the 1980s, 97% of persons enrolled in employer plans received some coverage for inpatient mental health care and 95% received partial coverage for outpatient care. McGuire, 72 Milbank Q. at 5 (citation omitted).

11. See Ridgely and Goldman, 40 St. Louis U. L. J. at 415 (cited in note 9) (stating that of all beneficiaries of medium to large commercial insurance companies, only 37% were covered for inpatient mental health care and only 6% for outpatient services). In the 1950s, benefits for mental health and alcohol and substance abuse disorders ("ADM benefits") were on par with physical health benefits until overutilization led to limitations on ADM benefits. *Id.* at 411. Though the 1970s and 1980s saw a general expansion in private health coverage, cost containment efforts by the private sector in the mid-1980s shifted the burden of mental health care costs back to the public sector. Steven S. Sharfstein and Anne M. Stoline, *Reform Issues for Insuring Mental Health Care*, 11 Health Affairs 84, 86 (Fall 1992).

12. Though the discussion of mental health benefits often encompasses substance abuse treatment, for purposes of this Note, substance abuse treatment is not included in "mental health benefits" unless specifically indicated.

13. Leonard S. Rubenstein, *Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care*, 40 St. Louis U. L. J. 315, 323 (1996). These limitations, for pur-

need to keep premiums affordable and the perception that diagnosis and treatment of mental health is less reliable and effective than treatment of "regular" physical medical care are the primary reasons for the commonality of these limitations.¹⁴

While commentators have advocated more equality in insurance coverage,¹⁵ the concept of parity between mental health coverage and other medical coverage in insurance plans did not gain national prominence until the 1990s, when the issue came to the forefront of legal scholarship.¹⁶ In addition, mental health parity finally had congressional allies on both sides of the aisle—most notably, Republican Senator Pete Domenici of Arizona.¹⁷ Recent parity efforts have focused on eliminating the use of mental illness limitations—primarily annual and lifetime monetary caps, durational inpatient and outpatient limits, coinsurance rates, and deductibles¹⁸—that are set at lower levels than limitations on physical health care.

poses of this Note, include annual and lifetime monetary caps, annual inpatient hospitalization and outpatient visit caps (also referred to as "durational limits" or "day limits"), and unequal coinsurance or copayment rates. Monetary caps limit the total amount of dollars that are available for coverage of mental illness in a given year or lifetime. For example, in the typical plan, the maximum reimbursement for mental/nervous conditions is \$50,000, while the cap on benefits for physical conditions is \$1,000,000. *Compromise on Senate Parity Provision Aims to Keep Issue Alive in Conference*, 4 Health Care Policy Rep. (BNA) 1185, 1185-86 (July 22, 1996). Durational limits set caps on the number of days of inpatient hospitalization or outpatient treatment that a given plan will cover. Many plans impose no limits on the number of inpatient days allowed for physical care, while limiting inpatient days for mental health care to between thirty and sixty per year. Youndy C. Cook, Comment, *Messing With Our Minds: The Mental Illness Limitation in Health Insurance*, 50 U. Miami L. Rev. 345, 345 n.2 (1996). Coinsurance and copayments refer to the percentage amount of costs or the set dollar amount that must be paid by the insurance beneficiary for each visit.

14. According to a 1989 survey, 87% of employers providing health benefit plans imposed a limitation on inpatient mental health care. *Survey, Response Highlight Managed-Care Controversy; Limitations on Treatment for Substance Abuse and Mental Disorders*, 3 Alcoholism & Drug Abuse Week 3, 4 (Jan. 30, 1991) ("Survey"). This figure represented a 12% increase in the use of these limitations since 1988. *Id.*

15. Ridgely and Goldman, 40 St. Louis U. L. J. at 428 (cited in note 9) (noting that "the concept of 'parity' has been a rallying cry for advocates of more comprehensive" mental health care benefits).

16. See generally Rubenstein, 40 St. Louis U. L. J. at 315 (cited in note 13); Cook, 50 U. Miami L. Rev. at 345 (cited in note 13); Brian D. Shannon, *The Brain Gets Sick Too—The Case for Equal Insurance Coverage for Serious Mental Illness*, 24 St. Mary's L. J. 365 (1993); Wayne E. Ramage, Note, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 Vand. L. Rev. 951 (1992); Rubin, 28 Houston L. Rev. at 143 (cited in note 1).

17. Senator Domenici has repeatedly introduced parity proposals in Congress. See notes 19 and 170 (citing to two such Domenici proposals).

18. See note 13 (discussing these limitations). While these limits seem to be the primary policy focus, commentators urge for a broader notion of "parity." See Rubenstein, 40 St. Louis U. L. J. at 323 (cited in note 13) (adding access to a broader range of services to the notion of parity); Ridgely and Goldman, 40 St. Louis U. L. J. at 428 (cited in note 9) (stressing the need for overall "fairness" in benefits decisions as opposed to identical benefits).

Attention to parity, however, did not translate into success for mental health advocates. Early congressional parity proposals met with defeat,¹⁹ and President Clinton's plan for universal coverage, which included substantial, though limited mental health benefits,²⁰ failed. Furthermore, although Congress finally enacted the Mental Health Parity Act of 1996 ("MHPA")²¹ it was not the sweeping victory for mental health advocates that its title suggests. While signaling a possible first step in the right direction, the MHPA only restricts the use of unequal annual and lifetime monetary caps on mental health services, leaving other important limitations untouched and setting no federally-mandated minimum benefit levels.²² This Note argues, in part, that the MHPA is a common phenomenon in health care legislation: broad, idealistic access goals severely undercut by cost containment concerns.²³ In the MHPA, this phenomenon is evidenced by the substantial difference between the original broad parity proposal that was defeated and the narrow provision finally enacted.

The provisions in the Americans with Disabilities Act ("ADA")²⁴ regarding insurance and benefit plans²⁵ appear to be part of the same legislative trend. Rather than explicitly and clearly addressing these cost containment concerns to protect those with mental disabilities, Congress created a confusing statutory provision that potentially affords no protection against "discriminatory" limitations and reductions. Nonetheless, the EEOC's interpretation of the ADA and recent judicial decisions suggest that various insurance practices may face scrutiny under the ADA.

19. Senator Domenici first introduced parity-type legislation in 1992. See "Equitable Health Care for Severe Mental Illnesses Act of 1992," S. 2696, 102d Cong., 2d. Sess. (May 12, 1992), in 138 Cong. Rec. S6490 (May 12, 1992). The bill, however, never became law.

20. Initially, the Clinton plan would have covered fewer days for both inpatient and outpatient care of mental illness than for general medical care. *Clinton Plan Includes Mental Health Benefits—But Are They Enough?*, 68 *Hospitals & Health Networks* 46, 46 (1994). The goal, however, was to reach full parity for mental health benefits by the year 2001. *Id.* See also Ridgely and Goldman, 40 *St. Louis U. L. J.* at 425-27 (cited in note 9) (discussing the important victories for mental health advocates during President Clinton's attempts at health care reform).

21. Pub. L. No. 104-204, 110 Stat. 2944 (1996).

22. Most importantly, the MHPA does not restrict the use of unequal durational limits or coinsurance ratios. MHPA § 712(b)(2), 110 Stat. at 2946.

23. One commentator has termed this phenomenon "legislative schizophrenia." James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 *Iowa L. Rev.* 1227, 1227 (1984). For a full discussion of this phenomenon in the context of the MHPA and the Americans with Disabilities Act ("ADA"), see Part IV.A.

24. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat 327, codified at 42 U.S.C. §§ 12101 et seq. (1994 ed.).

25. 42 U.S.C. § 12201(c).

This Note analyzes the federal protections (or lack thereof) extended to private mental health insurance benefits—in particular those provided through employment-based plans—under the MHPA and the ADA. Part II discusses the competing views and provisions of the MHPA and the limited impact it is likely to have on the ability of those suffering from mental illness to secure private insurance benefits. Part III attempts to determine whether the ADA provides any protection for persons with mental disabilities seeking to secure access to private insurance funds and concludes that the ADA is not a viable source of relief. Part IV discusses the legislative parallels between the MHPA and the ADA and the future implications of these parallels. Part IV also analyzes potential legislative compromises that would provide persons with mental illness greater access to private health insurance funds, while stopping short of providing complete parity of insurance for mental and physical illness. Part IV concludes with a brief discussion of managed mental health care²⁶ and the additional parity issues it raises.

II. THE MENTAL HEALTH PARITY ACT OF 1996

A. *The Competing Views*

1. Justifications for Mental Health Limitations

Insurers and employers stress cost containment as the primary justification for mental illness limitations.²⁷ There are several

26. For the purposes of this Note, the terms “managed mental health care” and “managed care” refer to health plans that use various forms of utilization review to monitor the delivery of care as a means of controlling costs. Rubin, 28 *Houston L. Rev.* at 161 (cited in note 1). This approach to health insurance differs from the traditional fee-for-service approach, in which providers determine the necessary care, and attendant costs are reimbursed by insurance companies without any review of the provider’s decision or the necessity of care. Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 *Seton Hall L. Rev.* 1007, 1009 n.1 (1996).

27. Insurers seek to contain costs through risk classification. On the individual level, the insurers try to measure the burden that a policyholder will place on the insurance pool and then charge premiums that reflect that burden. Leah Wortham, *Insurance Classification: Too Important to Be Left to the Actuaries*, 19 *U. Mich. J. L. Ref.* 349, 361 (1986) (describing the “fair discrimination” perspective of classification). In the group underwriting setting, low-risk enrollees and high-risk enrollees offset one another. H. Miriam Farber, Note, *Subterfuge: Do Coverage Limitations and Exclusions in Employer-Provided Health Care Plans Violate the Americans with Disabilities Act?*, 69 *N.Y.U. L. Rev.* 850, 866 (1994). In such plans, rather than individually charging particular enrollees higher premiums and then providing the same

dimensions to this cost argument. First, employers argue that limiting services, such as those related to mental healthcare, is necessary to guarantee access to health care to a greater number of people. Parity, they contend, could eliminate some individuals from existing programs by causing an increase in rates or by causing employers to drop coverage altogether.

Insurers also offer two other cost arguments against parity: moral hazard and adverse selection. Moral hazard posits that demand for services increases when insurance covers the services.²⁸ In the case of mental illness, this concern is heightened because individuals "might claim to suffer from an illness when they are actually suffering from life."²⁹ In addition, clinicians can find ways to avoid insurance restrictions.³⁰ The premise underlying this view, and insurers' view of mental health care in general, is that diagnosis and treatment of mental health disorders is more uncertain and less effective than diagnosis and treatment in other areas in medicine.³¹

benefits to all employees at the same cost, employers commonly contain costs by imposing across-the-board limitations, such as a mental illness coverage limitation. *Id.* at 867 n.99.

28. See David Mechanic, *Mental Health Services in the Context of Health Insurance Reform*, 71 *Milbank Q.* 349, 352-53 (1993). Mechanic explains:

Economists focus on "moral hazard," which is an inclination to use services more when they are fully insured in contrast to use under varying copayment arrangements. Use of outpatient mental health services is more responsive to price than is use of general medical services, leading to the belief that cost barriers are more necessary in the provision of these services.

Id. (citations omitted).

29. James E. Sabin and Norman Daniels, *Determining "Medical Necessity" in Mental Health Practice*, 24 *Hastings Center Rep.* 5, 9-10 (Nov./Dec. 1994).

30. *Id.* at 12 ("Insurance administrators are acutely aware that clinicians can always find ways to circumvent insurance restrictions."). This assertion has some empirical basis. See *id.* (reporting a poll in which 68% of physicians admitted their willingness to deceive third-party payers when they believe coverage to be unfair). See Richard E. Vatz and Lee S. Weinberg, *We Should Avoid Mental Health Insurance*, *U.S.A. Today (Magazine)* 34, 34 (Nov. 1994) (reporting a television investigation revealing a scandal in which psychiatric hospitals falsely diagnosed patients as having severe mental illness for insurance purposes).

31. See John K. Iglehart, *Managed Care and Mental Health*, 334 *New Eng. J. Med.* 131, 131-135 (1996) ("The nature of mental illness—its less well-defined boundaries and the greater uncertainty of clinical diagnosis and treatment—has left most payers unwilling to provide unlimited coverage."). Sabin and Daniels, 24 *Hastings Center Rep.* at 5 (cited in note 29) ("Many insurance administrators believe that judgments about medical necessity [i.e., appropriateness of treatment] in mental health are less precise than similar judgments in other areas of medicine."). This issue causes a considerable divergence of opinions. Some commentators apparently assume the view of insurers to be true. See Mechanic, 71 *Milbank Q.* at 354 (cited in note 28) (noting that "standards for psychiatric inpatient care are less clear than for medical and surgical care, and . . . psychiatric diagnosis is a particularly poor indicator of resource need or use."). Others challenge the validity of this notion, especially in the context of serious mental illness. See Shannon, 24 *St. Mary's L. J.* at 369 (cited in note 16) (discussing the efficacy of treatment for several mental illnesses). Regardless, disagreement does seem to exist among mental health professionals concerning the proper treatment and outcome in mental health care, Petrilá, 40 *St. Louis U. L. J.* at 391 (cited in note 1), and there is relatively little

The economic justification for not providing care that is subject to moral hazard is that such care is not truly worth its price; beneficiaries would not have sought the care if they had to pay the entire cost themselves.³²

The second argument regarding cost is adverse selection. Both employers and insurers fear that offering mental health coverage will attract a large number of high risk enrollees, since most plans lack such coverage.³³ The increased number of high risk enrollees raises costs and again forces either a reduction in coverage or an increase in premiums.

Employers and insurers also invoke the safety net of public services as a justification for mental illness limitations. Though limitations may lead to the exhaustion of benefits by the severely ill, state mental health systems provide a form of catastrophic coverage, relieving the insurer of ultimate responsibility for the insured's costs.³⁴

The business community naturally supports allowing market forces to determine the coverage of mental health benefits, presumably confident that the market can best allocate the scarce resources available for health care. Employers cite to the fact that overall enrollee interest in mental health benefits is low compared to that of

proof of the effectiveness of treatment for mental illness. Philip Boyle, *Managed Care in Mental Health: A Cure or a Cure Worse Than the Disease?* 40 St. Louis U. L. J. 437, 440 (1996) (suggesting at least some recognizable difference exists between the two kinds of care).

The question remains, however, whether this difference warrants a lower level of coverage for mental illness, especially when the suffering of those with mental illness arguably is no less than those with physical illness. Many who defend unequal treatment argue that those with mental illness have either caused their own problems or are hopelessly incurable, therefore deserving fewer benefits. See Boyle, 40 St. Louis U. L. J. at 440. Advocates, however, consider this point of view "overstated", *id.*, and stress that some mental illnesses are treatable. Shannon, 24 St. Mary's L. J. at 369 (cited in note 16).

32. Frank and McGuire, 9 Health Affairs at 41 n.10 (cited in note 10).

33. The fact that a large percentage of the cost associated with mental health services is comprised of expenditures on a few severely ill patients further bolsters this fear. See Donald M. Steinwachs, Judith D. Kasper, and Elizabeth A. Skinner, *Patterns of Use and Costs Among Severely Mentally Ill People*, 9 Health Affairs 178, 178 (Fall 1992) ("Although individuals with severe mental illness represent a small proportion (5-10 percent) of all individuals having a mental illness, it is estimated that they account for approximately 40 percent of specialty care expenditures and probably about the same proportion of total expenditures") (footnote omitted).

States have mandated minimum mental health benefits as a means of combatting the effects of adverse selection. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 729-31 (1984) (outlining the rationale behind Massachusetts's minimum mental health benefits mandates). Adverse selection, for example, drives up the cost of a particular plan for individuals who would otherwise buy mental health insurance. *Id.* at 731. Minimum mandates can combat this result by "effectively forcing the good-risk individuals to become part of the risk pool, and enabling insurers to price the insurance at an average market rather than a market retracted due to adverse selection." *Id.*

34. Frank and McGuire, 9 Health Affairs at 35 (cited in note 10).

other services and to interest in maintaining lower premiums.³⁵ In short, employers argue that fewer restrictions on the ability to tailor health plans, including a freedom from parity requirements, would allow for better total cost control, benefiting the entire health care system and fulfilling consumer desires.³⁶

2. The Case for Mental Health Parity

Mental health advocates refer to mental health limitations as “the last bastion of open discrimination in health insurance in this country.”³⁷ They argue that public and political biases and the stigma attached to those with mental illness are the primary sources of mental health coverage limitations.³⁸ This argument can be used to undermine many of the arguments in favor of the limitations. Bias could be present in the insurer’s view of the clinical uncertainty of

35. See *id.* at 35-36 (listing lack of enrollee interest as a reason for the prevalence of limited mental health coverage). Note, however, that Frank and McGuire attribute this lack of interest to “denial, underestimation of the effectiveness of mental health services, stigma associated with mental illness, or undervaluing benefits of service use that may accrue to wider populations.” *Id.* As a result, they suggest that regulation of mental health coverage may be justified. *Id.* at 36.

One should also note that this lack of enrollee interest does not alleviate the insurer’s adverse selection fear that high-cost enrollees who represent a small percentage of the overall enrollees to health plans—namely the severely mentally ill—will choose an insurance plan based on the availability of mental health coverage.

36. See Susan Nanovich Flannery, *Employer Health-Care Plans: The Feasibility of Disability-Based Distinctions Under ERISA and the Americans with Disabilities Act*, 12 Hofstra Labor L. J. 211, 248 (1995) (suggesting that perhaps if ERISA governed without the interference of state insurance regulations, employers could manage their benefit plans in the most efficient manner).

37. *CBO Analysis Doesn’t Tell Full Story on Mental Health Parity, Coalition Says*, 4 Health Care Policy Rep. (BNA) 908 (May 27, 1996) (quoting a press release by the Coalition for Fairness in Mental Illness Coverage).

38. From a historical perspective, the mentally ill have traditionally received substandard treatment in Anglo-American society. See Ramage, 45 Vand. L. Rev. at 951 (cited in note 16) (noting that in England, inmates of Bedlam Prison, a famous insane asylum, were exhibited to the public for a fee). A lack of funding for treatment and care and for the education of the public keeps both scientific and societal knowledge of their plight at a minimum. See, Orentlicher, 31 Harv. C.R.-C.L. L. Rev. at 51 (cited in note 4) (stating that “the stigma of psychiatric illness has led researchers and funders of research to neglect psychiatric illness when developing treatments for disease”). Under this view, insurance limitations become direct evidence of the intentional and structural bias against the mentally ill.

Though this bias certainly exists to some extent, the political support given and the lip service paid to the parity issue belies the notion that some kind of outdated prejudice against those with mental illness is the sole barrier to reaching parity. The expansion of mental health benefits in the early 1980s followed by cutbacks over the subsequent years suggests that cost concerns, not bias, are the real root of these limitations. See Gloria Ruby, *The Policy Implications of Insurance Coverage for Psychiatric Services*, 7 Int’l J. L. & Psych. 269, 271 (1984) (attributing the expansion of mental health services to, among other things, “public acceptance of psychiatric treatment”).

mental health, while the stigma attached to receiving treatment for mental illness could also explain the low demand for mental health coverage from consumers.³⁹ In addition, bias results in undereducation regarding mental health. This lack of education undermines the market choice solution advocated by insurers, since consumers with incomplete or biased information are incapable of making fully informed decisions necessary for the proper functioning of the marketplace. Finally, bias eliminates the moral hazard argument because an uninformed and fearful public⁴⁰ will not actively seek mental health services.⁴¹

As a corollary to the bias argument, commentators have argued that no sound biological basis for the differential treatment of certain psychological disorders and physical disorders exists.⁴² Legal

39. See Ramage, 45 Vand. L. Rev. at 972-75 (cited in note 16) (discussing the role that the stigma attached to mental illness has played in the undervaluing of mental health care by society as a whole).

40. For a study of public perceptions of mental illness, see generally Andrew B. Borenstein, *Public Attitudes Toward Persons with Mental Illness*, 11 Health Affairs 186 (Fall 1992). In particular, Borenstein notes that the stigma associated with seeing a psychiatrist has lessened over the last two decades. *Id.* at 187. However, a vast majority of Americans reported that they were not well-informed about mental illness. *Id.* at 188-89.

41. Studies have estimated that 15% of the population has a mental disorder, but only one quarter of these individuals seek treatment. McGuire, 72 Milbank Q. at 3 (cited in note 10).

42. Ridgely and Goldman, 40 St. Louis U. L. J. at 415-16 (cited in note 9). Scientific research has shown that several severe psychological disorders are actually due to chemical imbalances in the brain. Shannon, 24 St. Mary's L. J. at 367-70 (cited in note 16). These disorders include schizophrenia, bipolar disorder, and depressive illness. *Id.* at 367. In addition, studies have demonstrated the efficacy of treatment for these disorders. *Id.* at 369. As a result, some argue, they should be treated like any other brain disorder such as Alzheimer's disease. *Id.* Although "behavioral disorders" and "physical diseases" are both classified under the label "mental illness," Shannon draws a sharp distinction between the two. *Id.* at 372-74 (arguing that "[p]olicy limitations or other cost controls may be entirely appropriate for purely behavioral or emotional problems"). But see M. Gregg Bloche and Francine Cournois, *Mental Health Policy for the 1990s: Tinkering in the Interstices*, 15 J. of Health Politics, Policy & L. 387, 399 (1990) (referring to the depiction of mental illness as "an exclusively biological problem" as a "caricature"). The danger of the purely biological approach is the creation of sharp distinctions regarding not only the origin of the illness, but also the type of care given. *Id.* For example, those individuals suffering from a biological illness, such as schizophrenia, require care that closely resembles the care required for exclusively emotional or stress-related problems. See *id.* (stressing the need for non-biological interventions for the treatment of schizophrenia). The problem with these origin-based arguments is that insurers are not really concerned about the etiology of the disorders, but rather the cost, effectiveness, and certainty involved in their treatment and diagnosis. While treatment for biologically-based mental disorders may be effective, it is still a complex and long-term solution. Bloche and Cournois, 15 J. of Health Pol., Policy & L. at 399 (cited in this note) (stressing the need for "[p]sychotherapy, family education, occupational and social rehabilitation, and other psychosocial interventions" in addition to biological interventions for effective treatment of schizophrenia). However, treatment for severe mental illness is as effective as treatment for some physical illnesses, such as heart disease. When introducing his proposal, Senator Domenici stated, "Treatment for schizophrenia has a 60 percent success rate; manic depression, 80 percent; major depression, 65

commentators have criticized the limitations because of judicial uncertainty generated by challenges to the denial of benefits.⁴³ They argue that the conflicting approaches the courts use to determine whether certain illnesses are "mental" or "physical" result in inequities and shed light on the inconsistencies and unfairness inherent in the limitations.⁴⁴

Individuals in favor of parity also argue the offset costs inherent in providing mental health coverage would lead to an overall reduction in health care and social costs.⁴⁵ The warring factions in recent debates over parity, however, disagreed over the projected costs of parity. Not surprisingly, the business community studies revealed large premium increases and cutbacks in other areas of coverage, while mental health advocate studies showed far lower overall costs.⁴⁶ The Congressional Budget Office also conducted a study, which concluded that the costs of parity would be substantial, but not necessarily overwhelming.⁴⁷ Ultimately, these studies showed

percent. Yet commonly reimbursed procedures such as angioplasty and arthroscopy have only a 41 percent and a 52 percent ratio. . . ." 142 Cong. Rec. S3591 (Apr. 18, 1996).

43. See note 55 and accompanying text (discussing the diverse judicial approaches to these challenges).

44. Cook, 50 U. Miami L. Rev. at 360 (cited in note 13) ("The only distinction at this point seems to be between one group of insureds whose illnesses manifest themselves in socially stigmatized ways and another group of insureds whose illnesses are more acceptable as physical injury or disease.").

45. See Denis J. Prager and Leslie J. Scallet, *Promoting and Sustaining the Health of the Mind*, 11 Health Affairs 118, 120 (Fall 1992) (attributing psychological factors to backaches and cancer and stating that studies are beginning to show "the role of mental state in the maintenance and deterioration of good physical health and in the treatment of and recovery from physical illness" (citations omitted)). Empirical evidence supports this assertion. A recent study determined that middle-aged adults suffering from depression or anxiety were twice as likely to develop hypertension as those who were calm and happy. Marilyn Elias, *High Blood Pressure Signals: Depression and Anxiety Are Keys*, U.S.A. Today D1 (Jan. 28, 1997).

Crime, suicide, homelessness, and lost productivity are also linked to mental illness. Ramage, 45 Vand. L. Rev. at 953-55 (cited in note 16). The percentage of the homeless population suffering from a mental disorder is estimated as being between 28% and 56%. *Id.* But see Bloche and Cournois, 15 J. of Health Politics, Policy & L. at 389 (cited in note 42) (arguing that "it is plainly wrong to conclude, as some mental health professionals have, that the problem of homelessness is largely a consequence of inadequately treated psychiatric illness" (citations omitted)). According to some estimates, the costs of depression to employers are \$44 billion a year, "55 percent of that attributed to absenteeism, lowered productivity, and other factors that are difficult to measure." Janet Gemignani, *Mental Health Matters*, 14 Bus. & Health 66, 66 (Sept. 1996).

46. One such study sponsored by business groups found that premiums would increase by 8.3% to 11.4%, while a study sponsored by mental health advocates showed monthly premium increases of 2.5%. *Actuarial Reports Make Case for Parity in Insurance Reform*, 8 Alcoholism and Drug Abuse Week 1, 1 (April 22, 1996).

47. According to the CBO study, 800,000 workers and dependents potentially would lose employment-based coverage and employer-sponsored health insurance premiums would increase by 4%. *CBO Estimates Mental Health Parity Could Leave 400,000 Workers Uncovered*, 4 Health Care Policy Rep (BNA) 874 (1996).

the impossibility of agreeably predicting the economic impact that parity would have.

Parity proponents also argue that private insurance for mental illness is necessary to relieve taxpayers and underfunded state programs from the burden of providing mental health insurance.⁴⁸ Insurers, however, rely on the public safety net to care for those individuals requiring extraordinary amounts of care. Unfortunately, this "net" may not even exist for some individuals.⁴⁹

In short, mental health advocates conclude that mental illness coverage limitations are arbitrary and without sound basis.⁵⁰ Their argument for parity is a powerful moral and ethical imperative, and, were it not for economic costs, would be absolutely persuasive. Although proponents argue that costs should not be the decisive factor, Congress, as illustrated by the MHPA, apparently does not agree.

B. Background and Substance of the Mental Health Parity Act

1. Legal Background

States had already taken an active regulatory role in the regulation of mental health insurance before the MHPA. In 1989, thirty-eight states had some form of mandatory mental health benefits laws⁵¹ and, by 1996, seven had enacted parity-type legislation.⁵²

48. See generally Bloche and Cournois, 15 *J. of Health Politics, Policy, & L.* at 387 (cited in note 42).

49. Ramage, 45 *Vand. L. Rev.* at 972 (cited in note 16).

50. The sentiment of many mental health advocates is that these kinds of cost-containment devices simply do not effectively ration care. See 142 *Cong. Rec.* S3591 (April 18, 1996) (statement of Senator Domenici) (stating that "artificial costs measures to reduce utilization are a thing of the past"); Orentlicher, 31 *Harv. C.R.-C.L. L. Rev.* at 85 (cited in note 4) (arguing that flat caps that ration health care according to type of service should play a limited role under the ADA and in health care generally).

51. Mary Jane England, *Mental Health Care: Buyers Take the Lead*, 9 *Bus. & Health* 58, 58 (Jan. 1991). These mandates generally take two forms. One requires that plan enrollees have mental health coverage, while the other requires employers and insurers to offer the option of mental health coverage. David A. Lambert and Thomas G. McGuire, *Political and Economic Determinants of Insurance Regulation in Mental Health*, 15 *J. of Health Politics, Policy & L.* 169, 170-71 (1990). See, for example, Or. *Rev. Stat.* § 743.556(6) (1996 Supp.) (requiring a minimum level of benefits for mental illness and substance abuse of no less than \$10,500 for adults); Wis. *Stat. Ann.* § 632.89(2) (West, 1995) (requiring minimum day limits for inpatient and outpatient mental health and substance abuse treatment). The Supreme Court stated that one such statute was:

intended to help safeguard the public against the high costs of comprehensive inpatient and outpatient mental-health care, reduce nonpsychiatric medical-care expenditures for mentally related illness, shift delivery of treatment from inpatient to outpatient

Many of these state mandates, however, proved ineffective for securing adequate benefits.⁵³

The judiciary had also confronted cases concerning mental health coverage limitations prior to enactment of the MHPA.⁵⁴ In these cases, plaintiffs challenged limitations on insurance benefits for their biologically-based "mental" conditions by invoking the more generous standards applicable to "physical" illness.⁵⁵ These

services, and relieve the [state] of some of the financial burden it otherwise would encounter with respect to mental-health problems.

Metropolitan Life Ins., 471 U.S. at 731 (citation omitted) (discussing Massachusetts' statute).

52. These states are Maryland, Minnesota, Maine, New Hampshire, Rhode Island, North Carolina and Texas. *Mental Health Parity Laws Enacted in Seven States, Others Study Impact*, 5 Health L. Rep. (BNA) 1739 (Dec. 5, 1996). See, for example, 24-A Me. Rev. Stat. Ann. § 4234-A(6)-(7) (1996 Supp.) (requiring parity in group and individual insurance contracts for a certain number of severe mental illnesses); Md. Ann. Code art. 48A, § 490V(b)(1) (Michie, 1994) ("[E]ach contract or policy of health insurance may not discriminate against any person with a mental illness, emotional disorder or a drug abuse or alcohol abuse disorder by failing to provide benefits for . . . these illnesses under the same terms and conditions that apply . . . for treatment of physical illness."); N.H. Rev. Stat. Ann. § 415:18-a(I) (Equity, 1991 & 1996 Supp.) (requiring that mental health benefits be as favorable as certain other minimum benefits); R.I. Gen. Laws § 27-38.2-1 (1994) (requiring parity in coverage for "serious mental illness"); Tex. Ins. Code Ann. § 3.51-14 (Vernon 1997 Supp.) (listing five disorders or groups of disorders that qualify as "serious mental illnesses" that are to receive parity of coverage).

53. England, 9 Bus. & Health at 58 (cited in note 51).

54. For a fuller discussion of these cases and the relevant issues, see generally Cook, 50 U. Miami L. Rev. at 345 (cited in note 13); Shannon, 24 St. Mary's L. J. at 375-86 (cited in note 16); Ramage, 45 Vand. L. Rev. at 963-68 (cited in note 16).

55. In response, the judiciary developed three primary approaches: symptom/manifestation, causation, and treatment. Cook, 50 U. Miami L. Rev. at 348-49 (cited in note 13). But see *Klebe v. MITRE Group Health Care Plan*, 1996 U.S. App. LEXIS 17696, *5 (4th Cir. July 19, 1996) (concluding, without attempting to apply one of the three tests, that the term "mental health treatment" was unambiguous within the context of defendant's health care plan and "that treatment for chronic schizophrenia clearly falls under that umbrella").

Under the symptom/manifestation approach, courts look only at the outward manifestations of the illness to determine which insurance category to apply. Cook, 50 U. Miami L. Rev. at 348 (cited in note 13). See *Equitable Life Assurance Society v. Berry*, 260 Cal. Rptr. 819 (Cal. Ct. App. 1989), in which the court sustained the denial of disability benefits to a manic depressive pursuant to a mental illness limitation. Though expert testimony claimed manic depression had an organic cause, the court stated "[m]anifestation, not cause, is the yardstick." *Id.* at 824 (footnote omitted). See also *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990) (concluding that affective mood disorder fell under a mental illness limitation because a layperson would consider behavioral manifestations as determinative for purposes of insurance classification). Invariably, courts applying the symptom/manifestation approach ruled in favor of the insurance companies.

In contrast, courts applying the causation approach looked to the origin of the illness and were more likely to allow plaintiffs the greater "physical" illness benefits. Cook, 50 U. Miami L. Rev. at 358 (cited in note 13). See, for example, *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp. 1342, 1346 (C.D. Cal. 1988) (defining mental illness as a "behavioral disturbance with no demonstrable organic or physical causes"). These outcomes resulted from the courts' willingness to entertain expert testimony that certain mental illnesses were organic in origin. Cook, 50 U. Miami L. Rev. at 358 (cited in note 13).

Finally, under the treatment approach, courts consider whether the type of care given is "psychiatric" or "medical" in nature in determining the extent of policy coverage. *Id.* at 353-54.

challenges, however, met with inconsistent results and limited long-term success because insurers could adjust their policy language to preclude judicial intervention.⁵⁶ Mental health advocates thus saw the MHPA as long overdue.

The federal government regulates employer-provided benefit plans through the Employment Retirement Income Security Act ("ERISA").⁵⁷ Although the pre-MHPA ERISA contained a non-discrimination provision,⁵⁸ the scope of this provision did not reach benefit limitations.⁵⁹ As a result, advocates called for parity legislation addressing these concerns.

In 1996, many attempts at passing parity legislation were based on expansive notions of equality and called for a broad parity mandate requiring employers and insurers to impose only those financial limitations on mental health care that they imposed upon coverage for other conditions.⁶⁰ To the surprise of many, one such proposal by Senators Domenici and Wellstone passed the Senate by a vote of sixty-eight to thirty.⁶¹ The Domenici-Wellstone proposal would have eliminated differential treatment of mental health conditions with regard to annual and lifetime dollar caps, inpatient and

Courts primarily used this approach in instances in which the insurance plan limits the type of care or treatment that can be provided. *Id.*

56. *Id.* at 359.

57. Pub. L. No. 93-406, 88 Stat. 829, codified at 29 U.S.C. §§ 1001 et seq. (1994) ("ERISA"). For a full discussion of the treatment of employee health plans under ERISA, see Flannery, 12 Hofstra Labor L. J. at 213-27 (cited in note 36).

58. 29 U.S.C. § 1140 ("It shall be unlawful for any person to . . . discriminate against a participant or beneficiary . . . for the purpose of interfering with the attainment of any right to which such participant may become entitled under [an employee benefit] plan").

59. In *McGann v. H. & H. Music Co.*, 946 F.2d 401 (5th Cir. 1991), the court specifically held that an employer's reduction in benefits under ERISA for Acquired Immunodeficiency Syndrome ("AIDS") did not discriminate against an employee suffering from that disease. *Id.* at 408. The broader and more significant holdings were that ERISA did not require employers to provide any particular benefits and that employers had the absolute right to determine the terms of their benefit plans. *Id.* at 406-07.

60. For example, a bill sponsored by Senators Domenici and Wellstone stated:
 PROHIBITION.—An employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, shall not impose treatment limitations or financial requirements on the coverage of mental health services if similar limitations or requirements are not imposed on coverage for services for other conditions.
 S. 1028, § 305(a), 104th Cong., 2d Sess. (April 18, 1996), in 142 Cong. Rec. S3670 (Apr 18, 1996).

A later proposal, introduced by Representative Pete Stark, amended the Internal Revenue Code to impose a 25% tax on the premiums received by an insurer who imposed "limitations or financial requirements" on the coverage of mental illness, unless similar limitations were imposed on other covered conditions. 142 Cong. Rec. E1551-52 (Sept. 10, 1996) (summarizing the National Mental Health Improvement Acts of 1996, H.R. 4045, 104th Cong., 2d Sess. (1996)).

61. Specifically, a motion to table the amendment was rejected by the sixty-eight to thirty vote, and the bill was subsequently adopted by voice vote. 54 Cong. Q 1077 (1996).

outpatient hospitalization limits, and coinsurance rates.⁶² The proposal would not, however, have affected the use of preadmission screening or the limitation of coverage to "medically necessary" services.⁶³

The business community strongly opposed the Domenici-Wellstone bill. Lobbyists produced studies claiming to show that the proposal would have a devastating effect on premiums and the number of Americans receiving health insurance coverage.⁶⁴ Moreover, despite Senate approval, individual Senators did not appear to fully support the bill. For example, Senator Robert Dole, shortly after affirmatively voting for the bill, stated "[t]hat's a very, very expensive provision, and it's going to cause all kinds of problems."⁶⁵ The bill ultimately succumbed to such opposition in the conference committee for the Health Insurance Portability and Affordability Act.⁶⁶

Senators Domenici and Wellstone, however, had not given up their effort to push parity legislation through Congress in 1996. In a "last-minute maneuver," the senators successfully attached a more limited piece of parity legislation, the current MHPA, to the VA-HUD Appropriations Bill,⁶⁷ which passed the Senate.⁶⁸ Despite opposition from employer groups, President Clinton signed the bill on September 26, 1996.⁶⁹

2. The Legislative "Compromise": What Does the Act Accomplish?

Compared to the broad scope of the original proposal, the MHPA accomplishes very little. It only requires parity for lifetime

62. S. 1028, § 305(b), 104th Cong., 2d. Sess. (Apr. 18, 1996), in 142 Cong. Rec. S3670 (Apr. 18, 1996).

63. *Id.* Had the bill passed, the exemption of these practices would have been crucial to its effect on managed care. See Part IV.B.3 (discussing the use of "medical necessity" in managed care).

64. See *Employer Groups' Study Bolsters Claims of Negative Side of Mental Health Parity*, 4 Health Care Policy Rep. (BNA) 995, 995 (June 10, 1996) (reporting a study that estimated the parity bill would cause a \$20 billion reduction in federal revenues, a loss of employer-sponsored insurance by 1.7 million workers and their dependents, and an 8.7% average increase in private health insurance premiums).

65. *Senate Passes Kassebaum-Kennedy Bill, Setting Stage for Conferencce with House*, 5 Health L. Rep. (BNA) 629 (Apr. 25, 1996).

66. Steve Langdon, *Kennedy, Kassebaum Steer Insurance Bill to Safety*, 54 Cong. Q. 2197, 2197 (1996).

67. David Nather, *Insurance Regulation: Senate Attaches Maternity Stay, Mental Health Amendments to VA-HUD Bill*, 4 Health Care Policy Rep. (BNA) 1417, 1417-18 (Sept. 9, 1996).

68. The provision passed by an eighty-two to fifteen vote. 54 Cong. Q. 2555 (1996).

69. Jon Healey, *VA-HUD Spending Bill Clears With Bipartisan Support*, 54 Cong. Q. 2762, 2762 (Oct. 4, 1996).

and annual limitations on benefits.⁷⁰ If a plan imposes no such monetary limits on "substantially all medical and surgical benefits," then the plan may not so limit mental health benefits.⁷¹ If a plan does limit medical and surgical benefits, then the plan may either include mental health benefits under the category of medical and surgical benefits or treat mental health benefits as a separate category capped at an amount no less than that applicable to medical and surgical benefits.⁷² The Act specifically excludes cost sharing or coinsurance, day limits, and medical necessity requirements from its reach.⁷³

Though the limited nature of the MHPA ensures that employers will not simply stop offering health benefit plans, employers whose current plans utilize annual and lifetime caps may be exempted from the Act, or, in the alternative, choose from several options for maintaining cost controls on mental health benefits. The bottom line is that the Act does not require employers to include mental health benefits in its plans, nor does it require a plan option that includes mental health coverage.⁷⁴ Thus, the Act seems to punish those employers who do provide these benefits, while employers that refuse to provide benefits altogether receive no extra burden.

In addition, because the Act leaves employers free to use day limits and coinsurance rates without parity, cost-conscious employers will likely find a way to keep mental health costs at current levels.⁷⁵ For instance, employers using both a dollar and a day limit could resort to further minimizing the number of days allowed under a plan or could impose an exorbitantly high coinsurance rate.

While the original Domenici-Wellstone proposal would have required parity of benefits for all employers and insurance plans, the MHPA applies only to large and mid-sized employers.⁷⁶ Congress inserted this provision to placate fears that small employers faced with increased costs from one or two chronic users of mental health services would drop their benefit plans altogether. Of course, this concern ignores the simple fact that small employers could either opt out of mental health coverage altogether or use other types of

70. Mental Health Parity Act of 1996, § 712(a), Pub. L. No. 104-204, 110 Stat. 2945 (1996).

71. MHPA § 712(a)(1)(A), (2)(A), 110 Stat. at 2945.

72. MHPA § 712(a)(1)(B), (2)(B), 110 Stat. at 2945.

73. MHPA § 712(b)(2), 110 Stat. at 2946.

74. MHPA § 712(b)(1), 110 Stat. at 2946.

75. Employers who currently use annual or lifetime monetary caps have plenty of time to plan around the Act, which does not become effective until January 1, 1998. MHPA § 712(c)(2), 110 Stat. at 2947.

76. Employers with fewer than fifty employees are automatically exempted. MHPA § 712(c)(1), 110 Stat. at 2946.

limitations. The Act also exempts employers who incur a one percent increase in the cost of their plan⁷⁷ as a result of complying with the statute.⁷⁸ Finally, the Act allows for employer cost containment by giving employers the authority to define what constitutes "mental health benefits."⁷⁹

One could argue that the MHPA begins in the right place. Annual and lifetime caps are the most commonly used mental illness coverage limitation in traditional indemnity or fee-for-service plans,⁸⁰ presumably because they give insurers the most absolute cost protections. Because these caps are the most commonly used limitations in these types of plans, the MHPA arguably will have a greater impact than if the Act only eliminated durational limits or unequal coinsurance rates. Moreover, lifetime caps permanently end benefits for a small percentage of seriously ill people,⁸¹ regardless of the urgency or need for such services, while effectively subsidizing less expensive treatment for those with less severe conditions. The flexibility retained by employers and the emergence of managed care, however, suggest that the impact of the Act will be negligible.

77. One of the few internal issues regarding the Act is the determination of the one percent exemption. If employers cannot make this determination prior to the time that the Act becomes enforceable, they may suffer costs that the Act specifically seeks to avoid. Most likely, however, employers will have to first remove the caps on mental health care and then calculate their cost increase. Steve Findlay, *Figuring It Out*, 14 Bus. & Health 21, 22 (Nov. 1996).

78. MHPA § 712(c)(2), 110 Stat. at 2947.

79. MHPA § 712(e)(4), 110 Stat. at 2947. Treatment for alcohol and substance abuse disorders is automatically exempted from this definition, despite the fact that mental disorders and substance abuse are oftentimes coexistent. See Ridgely and Goldman, 40 St. Louis U. L. J. at 426 n.80 (cited in note 9) (reporting a 50% co-morbidity rate between mental illness and substance abuse). This approach may be something of a step back on the national scene, since President Clinton's failed attempt at universal coverage would have included coverage of substance abuse treatment. *Id.* at 426. This omission, however, could reflect concerns that substance abuse represents a very large part of the cost increases associated with mental illness. Shannon, 24 St. Mary's L. J. at 373 n.29 (cited in note 16) (citing substance abuse and adolescent treatment as the two major areas of escalating costs).

80. One study has shown that 58% of employer plans use maximum lifetime dollar limits, 28% use per year or benefit period dollar limits, 46% use day limits and 35% charge higher copayments for mental health inpatient care than for general medical treatment. *Survey*, 3 Alcoholism & Drug Abuse Week at 4 (cited in note 14).

81. See Vicki Baldassano, *Mental Health Parity Law May Boost Business for Managed Care*, 4 Health Care Policy Rep. (BNA) 1532, 1532 (Sept. 30, 1996) (reporting that 0.1% of covered patients exceed lifetime limits on mental health coverage).

C. Implications of the Mental Health Parity Act

1. Modifications to Employee Health Benefit Plans: Accelerating the Move to Managed Care

Though the MHPA eliminates lifetime and annual caps on mental health benefits, it does nothing to ensure that employers will not change their benefit plans to include other caps, such as limits on inpatient and outpatient days or higher coinsurance rates. Considering the already tight economic pressures on benefit plans, employers will most likely make these changes to control mental health care costs. As a result, the majority of individuals who receive mental health benefits will likely have to pay higher copayments and deductibles for their benefits. This policy could actually raise the overall expenditures of those who use mental health services—a result presumably in conflict with the goal of parity.

Another possible response by employers that is more favorable to those with a mental illness would be to lower the dollar caps applicable to general medical care to offset the increase in mental health coverage. This result seems unlikely, however, considering the flexibility provided by the MHPA and the market force of employees seeking greater health benefits. In other words, rather than shifting the costs of the Act onto those who could potentially exceed lower coverage limits on physical health, employers likely will leave the burden where it currently rests: on the mentally ill.

The prohibition on annual and lifetime caps for mental health coverage has little effect on managed care. Contrary to traditional fee-for-service plans, which commonly utilize such monetary caps, managed care plans primarily combine limits on inpatient and outpatient days with utilization review to contain the costs of mental health services.⁸² Compared to the failed Domenici-Wellstone proposal, which could have ended indemnity-type coverage,⁸³ the MHPA may only accelerate the move to managed care. The question

82. *Id.* at 1532. See Jo Brady and John Krizay, *Utilization and Coverage of Mental Health Services in Health Maintenance Organizations*, 142 *Am. J. Psych.* 744, 744 (1985) (reporting norms of thirty day limits on inpatient coverage, twenty outpatient visits, and copayments as high as \$30 per outpatient visit in a typical health maintenance organization).

83. One study regarding the sweeping parity proposal concluded: “[W]e expect the mental health parity provision in [the bill] to lead to the end of indemnity-type coverage.” *Negative Side of Mental Health Parity*, 4 *Health Care Policy Rep.* (BNA) at 996 (cited in note 64) (quoting a Price Waterhouse study of the Domenici amendment).

for the mental health community is whether this acceleration is a move in the right direction.⁸⁴

2. Policy Implications?

Under the best case scenario for mental health advocates, the MHPA signifies three things. First, its passage may stimulate public awareness, dialogue, and, eventually, public support for more expansive legislation. Second, the Act may show that a majority of Congress is truly concerned about the parity issue and is willing to dictate that private insurance resources be committed to that end. Finally, the Act may be an incremental step toward full parity.⁸⁵

More subtly, the enactment may show Congress's desire to further the move toward managed care in both the public and private sectors to help relieve budgetary problems.⁸⁶ This position may be explained by overriding cost concerns, since managed care has been effective at containing costs.⁸⁷ This near exclusive focus on costs, however, gives rise to the question of how committed Congress is to creating greater access to care for those with mental illness. Though couched in the rhetoric of antidiscrimination law, the MHPA actually does little to get to the heart of the "discrimination" it seeks to remedy. Instead, the MHPA may serve as a salve for the conscience of legislators who can now feel they have done their part in the fight for equal insurance benefits for those with mental illness.

84. See Part IV.B.3 (discussing potential advantages and disadvantages of managed mental health care).

85. Considering the historical role of the state in funding mental health services, however, it may not be feasible for the private sector immediately to assume care for the most severely ill. Bernard S. Arons, et al., *Mental Health and Substance Abuse Coverage Under Health Reform*, 13 *Health Affairs* 192, 199 (Spring 1994). As a result, incremental change may be the best approach to easing the private sector into its new financial burdens and could eventually fulfill the ultimate goals of advocates. See Ridgely and Goldman, 40 *St. Louis U. L. J.* at 408 (cited in note 9) ("History has taught that incremental change . . . has succeeded in accomplishing many of the advocates' goals."). But see Rubin, 28 *Houston L. Rev.* at 173 (cited in note 1) ("Using the 1990s as a time to make merely incremental changes to the existing collection of public and private programs may be a mistake").

While further legislation may be a possibility, some political commentators believe, at the very least, further debate is forthcoming. See *Health Insurance Expansion Proposals Could "Undermine" Employer-Based Health System, According to HIAA's Gradison*, 8 *Health News Daily* 1 (Nov. 13, 1996) (citing prediction by Bill Gradison, President of the Health Insurance Association of America, that further efforts toward mental health parity may be forthcoming in 1997).

86. See Iglehart, 334 *New Eng. J. Med.* at 131 (cited in note 31) (discussing Congress's desire to reduce spending for mental health care in Medicaid and Medicare and describing managed care as a "central tenet" of this initiative). The use of managed care in public programs could reduce the cost of such programs through the more efficient use of resources.

87. *Id.*

III. THE AMERICANS WITH DISABILITIES ACT AND MENTAL HEALTH BENEFITS

The MHPA forecloses the use of aggregate annual and lifetime dollar limitations in employee health plans on mental health services. This Part examines whether the ADA provides any relief for persons with mental disabilities from the remaining types of mental illness limitations. Though the answer likely is no, many mental health advocates have expressed either belief or hope that the ADA could provide such relief.⁸⁸

Two major legal obstacles impede the attempts of persons with mental disabilities who seek greater insurance benefits under the ADA. The first is a necessary showing that a mental illness limitation is a "disability-based" distinction warranting scrutiny under the ADA.⁸⁹ The second is the avoidance of the ADA's "safe

88. See Cook, 50 U. Miami L. Rev. at 365-66 (cited in note 13) (suggesting that the ADA mandate some coverage for those with severe mental illness); Orentlicher, 31 Harv. C.R.-C.L. L. Rev. at 85 (cited in note 4) (contending that day limitations on mental health treatment could be prohibited by the ADA under the proposed "destructured disability standard"); Ramage, 45 Vand. L. Rev. at 970-71 (cited in note 16) (arguing that mental illness limitations could be found to be subterfuges to evade the purposes of the ADA).

89. The EEOC has determined that before a suit against a discriminatory plan can be brought, the plaintiff must show that the plan uses a "disability-based" distinction. EEOC, *Interim Guidance on Application of ADA to Health Insurance* (June 8, 1993), reprinted in F.E.P. Man. (BNA) 405:7115, 7116 (1993) ("EEOC Guidance"). According to the EEOC, a distinction "is 'disability-based' if it singles out a particular disability . . . , a discrete group of disabilities . . . , or disability in general." *Id.* at 405:7118.

Conversely, health plan distinctions that are not based on disability and that are applied equally to employees regardless of disability cannot violate the ADA. *Id.* at 405:7117. For example, a mental illness limitation cannot violate the ADA if the distinction applies to a multitude of both disabling and non-disabling conditions and therefore cannot be said to discriminate on the basis of disability. *Id.* at 405:7117-18. By contrast, a benefits cap on AIDS treatments could violate the ADA because the cap only affects those individuals with a disabling illness. *Id.* at 405:7118-19. This conclusion potentially would give relief to the plaintiff in *McGann*, see note 59, while refusing such relief to the mentally disabled.

As support for its position that mental illness limitations do not violate the ADA as disability-based discrimination, the EEOC cites to judicial decisions under the Rehabilitation Act. EEOC Guidance at 405:7118 n.9 (cited in this note) (citing *Doe v. Colautti*, 592 F.2d 704 (3d. Cir. 1979) (upholding a Pennsylvania program limiting care in a private mental hospital to sixty days) and *Doe v. Devine*, 545 F.Supp. 576 (D.D.C. 1982) (upholding cutbacks in Blue Cross mental health benefits for federal employees)).

The D.C. Circuit reaffirmed this outcome under the Rehabilitation Act. *Modderno v. King*, 82 F.3d 1059, 1065 (D.C. Cir. 1996). In addition, the Seventh Circuit has concluded that mental illness limitations in disability insurance are not discriminatory under the ADA. *EEOC v. CNA Insurance Co.*, 96 F.3d 1039, 1044-45 (7th Cir. 1996). The D.C. Circuit, however, declined to answer this question under the ADA when given the opportunity. *Modderno*, 82 F.3d at 1065 ("Whether or not Modderno stated a claim under the 1992 amendment of § 504 apart from the safe-harbor provision—a question on which we express no opinion—the coverage limitations challenged by Modderno cannot violate amended § 504.").

The problem with the EEOC's view is that it allows employers to discriminate in benefit plans against persons with mental disabilities, as long as the terms of the plans include both

harbor” for insurance and employee benefit plans. Under the general statutory framework of the ADA, a mental illness limitation could easily violate the ADA. Congress, however, created an apparent safe harbor, section 501(c),⁹⁰ which arguably protects all benefit plans from ADA scrutiny. Congress also inserted language, however, that creates an exception to the benefit plan exemption, thus possibly reopening some benefit plans to scrutiny. This Part limits its analysis to the two primary interpretations of this safe harbor provision and examines the vulnerability of mental health limitations under each interpretation.

A. *The Broad Goals of the ADA*

Congress enacted the ADA as a sweeping mandate to end discrimination against persons with disabilities⁹¹ in employment, public services, and public accommodations provided by private entities.⁹² The Act provides that no employer⁹³ “shall discriminate

persons with disabilities and the non-disabled. See Rubenstein, 40 St. Louis U. L. J. at 353 (cited in note 13) (stating that the EEOC’s “analysis . . . allows the manner in which medical conditions are grouped for coverage purposes in a health plan to control determinations about discrimination”). See also Mary T. Giliberti, *The Application of the ADA to Distinctions Based on Mental Disability in Employer-Provided Health and Long-Term Disability Insurance Plans*, 18 Mental & Physical Disability L. Rptr. 600, 602 (1994) (“Because of the EEOC’s position, persons with severe disabilities are unable to get care simply because their conditions fall into the ‘mental’ category.”).

Courts, however, are likely to maintain the logical premise that a distinction between mental and physical disabilities merely distinguishes between disabilities, not between the disabled and non-disabled. Antidiscrimination statutes such as the ADA only prohibit the latter type of discrimination. See *Modderno*, 82 F.3d at 1062 (concluding that discrimination against the mentally disabled as compared to the physically disabled was not the purpose of the Rehabilitation Act).

90. 42 U.S.C. § 12201(c).

91. 42 U.S.C. § 12101 (b) states:

It is the purpose of this chapter—

(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;

(2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;

....

(4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

92. Title I of the ADA addresses employment practices, Title II concerns public services, and Title III addresses public accommodations provided by private entities. See generally 42 U.S.C. §§ 12101 et seq.

93. The ADA actually uses the broader term of “covered entity” to reach most persons or organizations involved with employment in any capacity. *Id.* § 12111(2). An employer is defined as “a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and any agent of such a person . . .” *Id.* § 12111(5).

against a qualified individual with a disability⁹⁴ . . . in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment."⁹⁵ This broad mandate includes fringe benefits such as employee health insurance plans.⁹⁶ Moreover, the ADA explicitly extends to those employment practices that have a disparate impact on, as well as practices that amount to disparate treatment of, persons with disabilities.⁹⁷

The ADA's definition of disability includes any "physical or mental impairment that substantially limits one or more of the major life activities."⁹⁸ More specifically, a mental impairment is defined as "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities."⁹⁹

94. A "qualified individual with a disability" is defined as "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individuals holds or desires." *Id.* § 12111(8). Recent cases suggest that this term is especially important in the context of disability insurance. See, for example, *CNA Ins.*, 96 F.3d at 1041-44 (holding that the ADA did not cover the plaintiff's claim because plaintiff, suffering from severe depression and bipolar illness, was not a "qualified individual with a disability"). An in-depth discussion of this statutory term is beyond the scope of this Note.

95. 42 U.S.C. § 12112(a).

96. *Id.* § 12201(c).

97. *Id.* § 12112(b). "Disparate treatment" refers to employment practices that are intentionally aimed at discriminating on the basis of disability. Rubenstein, 40 *St. Louis U. L. J.* at 331 (cited in note 13). "Disparate impact" refers to employment practices that are facially neutral toward disability but have a disproportionate effect on the disabled. *Id.*

98. 42 U.S.C. § 12102(2)(A). In addition, anyone having "a record of such an impairment" or "regarded as having such an impairment" is considered disabled under the ADA. *Id.* § 12102(2)(B)-(C). Major life activities include caring for one's self, working, walking, speaking, learning, and breathing. 28 C.F.R. § 35.104 (1996).

The inclusion of mental disabilities under the ADA was an important victory for the mental health community. See 42 U.S.C. § 12211(b) (excluding transsexualism, sexual behavior disorders, voyeurism, compulsive gambling, and other similar "disorders").

99. EEOC, *A Technical Assistance Manual on the Employment Provisions (Title I) of the Americans with Disabilities Act II-2* (1992). This definition tracks the Rehabilitation Act of 1973's use of "handicap," providing a good guidepost as to what disorders qualify under the ADA. The courts have identified several mental impairments as handicaps under the Rehabilitation Act. See *Overton v. Reilly*, 977 F.2d 1190 (7th Cir. 1992) (mental and emotional illnesses that included severe depression); *Doe v. Region 13 Mental Health-Mental Retardation Comm'n*, 704 F.2d 1402 (5th Cir. 1983) (depressive neurosis); *Franklin v. U.S. Postal Service*, 687 F. Supp. 1214 (S.D. Ohio 1988) (paranoid schizophrenia); *Doe v. Syracuse School District*, 508 F. Supp. 333 (N.D.N.Y. 1981) (nervous breakdown and history of psychological treatment). See also John F. Fielder, *Mental Disabilities and the Americans with Disabilities Act: A Concise Compliance Manual for Executives* 114 (Quorum Books, 1994) (containing a comprehensive listing of cases that include mental illnesses under the Rehabilitation Act's definition of "handicap"). In fact, the Senate noted that the definition, with a few limited exceptions, covers the full range of disorders listed in the Diagnostic and Statistical Manual of Mental Disorders. Harvey S. Mars, *An Overview of Title I of the Americans With Disabilities Act and Its Impact*

Many insurance practices potentially violate the ADA under this general framework. Specifically, mental illness limitations that lack parity are highly suspect. Though such limitations may affect the disabled and non-disabled alike, they still have a disparate impact on those with disabling mental illness and therefore possibly violate the Act.¹⁰⁰ Rather than allowing this framework to govern the terms of health benefit plans, however, Congress created a safe harbor for many employers otherwise subject to the provisions—section 501(c).

*B. The Legislative “Compromise”: A Safe Harbor for Insurance and Employee Health Benefit Plans?*¹⁰¹

1. Introduction

Though Congress had not dealt with benefit limitations in ERISA,¹⁰² the ADA presented a new opportunity to do so. While persons with disabilities hoped the ADA would open a new line of attack against health coverage limitations, the insurance industry and employers hoped to maintain the flexibility that ERISA granted. The ADA’s response to this debate was section 501(c). Section 501(c) provides:

Subchapters I through III of this chapter and Title IV of this Act shall not be construed to prohibit or restrict:

- (1) an insurer, hospital, or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or
- (2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or

Upon Federal Labor Law, 12 Hofstra Labor L. J. 251, 256 n.26 (1995) (citing 135 Cong. Rec. S11,173-74 (Sept. 14, 1989)).

100. See Phillip G. Peters, *Health Care Rationing and Disability Rights*, 70 Ind. L. J. 491, 517 n.127 (1995) (noting that “broad exclusions, like that of mental health, are often closely related to a large category of disabled persons”); Ramage, 45 Vand. L. Rev. at 970 (cited in note 16) (“While ostensibly applying to all employees, such a limitation [on insurance benefits for mental illnesses] would have a disparate impact on” the mentally-disabled).

101. For the purposes of this Note, analysis of § 501(c) will be primarily limited to Supreme Court cases involving the ADEA, the EEOC Guidance, and recent case law under the ADA. For more in depth discussions of cases under the Rehabilitation Act, the Civil Rights Act and ERISA, see generally Flannery, 12 Hofstra Labor L. J. at 211 (cited in note 36); Farber, 69 N.Y.U. L. Rev. at 850 (cited in note 27); Monica E. McFadden, *Insurance Benefits Under the ADA: Discrimination or Business as Usual?*, 28 Tort & Insur. L. J. 480 (1993).

102. See notes 58-59 (discussing the scope of ERISA’s non-discrimination mandate).

administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

Paragraphs (1), (2), and (3) shall not be used as a subterfuge to evade the purposes of subchapter[s] I and III of this chapter.¹⁰³

At first glance, this provision appears to leave the current state of employee benefit plans and insurance practices untouched¹⁰⁴ so long as they are "bona fide"¹⁰⁵ and consistent with state law. It thus seems to allow employers to avoid the ADA's broad nondiscrimination requirements. However, the "subterfuge" clause has generated considerable controversy over the true reach of the exemption.

While commentators have grappled with the proper interpretation of section 501(c) for some time,¹⁰⁶ the courts have only recently begun to evaluate the meaning of the subterfuge provision. Two primary definitions of "subterfuge" have emerged. The first relies on the Supreme Court's interpretation of similar language under the Age Discrimination in Employment Act ("ADEA").¹⁰⁷ The second looks to the legislative history of the ADA and the EEOC's Enforcement Guidance.¹⁰⁸

2. The ADEA Definition

The Supreme Court first interpreted the term "subterfuge" in two cases under the ADEA, which contains an exemption provision for employee benefit plans similar to section 501(c). In *United Air Lines, Inc. v. McMann*,¹⁰⁹ the Court found the ADEA subterfuge clause

103. 42 U.S.C. § 12201(c).

104. This view is supported by legislative history which states: "In sum, section 501(c) is intended to afford insurers and employers the same opportunities they would enjoy in the absence of this legislation to design and administer insurance products and benefit plans in a manner that is consistent with basic principles of insurance risk classification." H.R. Rep. No. 101-485, 101st Cong., 2d Sess. 137-38 (1990).

105. A "bona fide" plan is one that "exists and pays benefits." *United Air Lines, Inc. v. McMann*, 434 U.S.192, 194 (1977).

106. These varying interpretations cover a broad spectrum. See, for example, Farber, 69 N.Y.U. L. Rev. at 907-14 (cited in note 27) (advocating an intent-based standard along the lines of Title VII Civil Rights Acts cases); McFadden, 28 Tort & Ins. L. J. at 501-502 (cited in note 101) (advocating a "cost-justification" test based on the Rehabilitation Act).

107. Age Discrimination in Employment Act of 1967, Pub. L. No. 90-202, 81 Stat. 602, codified at 29 U.S.C. §§ 621 et seq. (1994 ed.).

108. See generally EEOC Guidance (cited in note 89).

109. 434 U.S. 192 (1977). The plaintiff in *McMann* was automatically retired, over his objection, pursuant to a formal retirement income plan. *Id.* at 194. The plan had been insti-

unambiguous on its face, and thus assigned "subterfuge" its ordinary meaning: "a scheme, plan, stratagem, or artifice of evasion."¹¹⁰ Further, the *McMann* Court found that this definition required a showing of intent to evade the Act and rejected the business or economic purpose test that had been proffered by lower courts and the EEOC.¹¹¹

In *Public Employees Retirement System of Ohio v. Betts*,¹¹² the Court further concluded that to give proper effect to the ADEA's exemption for benefit plans, and not to render it "nugatory," a plan could not be a "subterfuge" unless it was "a method of discriminating in other, non-fringe-benefit aspects of the employment relationship. . . ."¹¹³ The *Betts* Court also held that the construction of the benefit plan exemption did not suggest that employers had to assert it as a defense, as the EEOC had concluded, but rather that the exemption "redefine[d] the elements of the plaintiff's prima facie case."¹¹⁴ Therefore, the burden of proof was on the plaintiff to show subterfuge.¹¹⁵

Under the ADA, several courts have followed the Supreme Court's ADEA interpretation of "subterfuge." The D.C. Circuit adopted the *Betts* definition when interpreting section 501(c) in *Modderno v. King*.¹¹⁶ The *Modderno* court found that the Supreme

tuted in 1941, long before the passage of the ADEA in 1967. *Id.* at 193. The relevant ADEA provision stated: "it shall not be unlawful for an employer . . . or labor organization to observe the terms of a bona fide seniority system or any bona fide employee benefit plan such as a retirement, pension, or insurance plan, which is not a subterfuge to evade the purposes of this" Act. *Id.* at 195-96 (quoting 29 U.S.C. § 623(f)(2)). Pursuant to an intent-based definition based on the ordinary meaning of "subterfuge," the Court concluded that a plan such as the one in dispute could not be a subterfuge to evade an Act that was passed twenty-six years later. *Id.* at 203.

Several years later, the Court revisited its definition of subterfuge in *Public Employees Retirement System of Ohio v. Betts*, 492 U.S. 158 (1989). In 1978, Congress amended the ADEA to change the result of *McMann*, but did not change, remove, or define the subterfuge language. *Id.* at 167-68. Though lower courts had treated this as a congressional rejection of the Supreme Court's interpretation of "subterfuge," the Supreme Court saw no reason to change its earlier interpretation because Congress had left the subterfuge language untouched. *Id.* at 168. Under this definition of "subterfuge" the Court once again denied relief to the plaintiff in question. *Id.* at 177. Following this ruling, Congress decided to remove the subterfuge language from the Act. *Modderno*, 82 F.3d at 1064.

110. *McMann*, 434 U.S. at 203.

111. *Id.*

112. 492 U.S. 158 (1989).

113. *Id.* at 177.

114. *Id.* at 181.

115. *Id.* at 181-82.

116. 82 F.3d 1059 (D.C. Cir. 1996). In *Modderno*, the ex-wife of a Foreign Service officer was hospitalized for mental illness from 1988 to 1991. *Id.* at 1060. She claimed that the \$75,000 lifetime cap placed on mental health benefits in 1991 under the Foreign Service Benefit Plan violated § 504 of the Rehabilitation Act, 29 U.S.C. § 794, as amended by § 501(c) of the

Court's ADEA definition was controlling because *Betts* was decided before Congress inserted the subterfuge language in the ADA.¹¹⁷ The *Modderno* court reasoned that Congress "was on full alert" of the Court's understanding of "subterfuge," and thus could have avoided the interpretation through the use of available "linguistic devices."¹¹⁸ In *Krauel v. Iowa Methodist Medical Center*,¹¹⁹ the Eighth Circuit explicitly adopted the reasoning of the D.C. Circuit,¹²⁰ refusing to accept legislative history that the plaintiff claimed showed Congress's intent to reject the *Betts* definition.¹²¹ Thus, both the Eighth Circuit and the D.C. Circuit have concluded that a benefit plan can only be a subterfuge under the ADA, and thus subject to full restrictions, if the employer intended to discriminate in a non-fringe benefit aspect of employment.

When the *McMann-Betts* definition of subterfuge is applied to the ADA, an employer cannot refuse to hire a qualified applicant with a mental illness merely because of a potential increase in the cost of insurance or because the employer's plan does not cover the applicant's disability.¹²² The plaintiff, however, carries a heavy burden of proof of discriminatory intent. The defendant-employer must only proffer some actuarial basis for the challenged decision to make the plaintiff's case rather difficult to prove. As a result, this definition of subterfuge still leaves current employee plan limitations and benefit reductions largely exempted from the ADA under the safe harbor provision of section 501(c).¹²³

ADA. *Id.* at 1063-64. The court rejected this claim, relying primarily on the Supreme's Court's specific holdings in *McMann* and *Betts* concerning pre-enactment plans. *Id.* at 1064-65. The plaintiff also claimed that the plan violated § 504 of the Rehabilitation Act, regardless of the ADA amendment. *Id.* at 1060-63. The court found that the plaintiff failed to state a claim under unamended § 504. *Id.* at 1063. Interestingly enough, the monetary cap in question would not violate the MHPA, which only applies to private employee benefit plans.

117. *Id.* at 1065.

118. *Id.*

119. 95 F.3d 674 (8th Cir. 1996).

120. *Id.* at 679.

121. *Id.* The court reasoned that if "Congress intended to reject the *Betts* definition of subterfuge when it enacted the ADA, it could have done so expressly by incorporating language for that purpose into the bill that Congress voted on and the President signed." *Id.*

122. See *Piquard v. City of East Peoria*, 887 F. Supp. 1106, 1123 (C.D. Ill. 1995) (noting that legislative history supports the "non-fringe benefits" interpretation in this regard).

123. See John English, Comment, *Self-Insured Group Medical Plans: A Search for Protection of Benefits*, 22 Cap. U. L. Rev. 749, 766 (1993) ("If the differences between the ADEA and the ADA are not significant, and the comparison between the two Acts is appropriate, employees like Jack McGann receive no help from the subterfuge clause of section 12201(c)."). See also note 59 (discussing *McGann*).

3. The EEOC Definition

The EEOC set forth its own definition of "subterfuge" in its interpretive guidance on the ADA. The EEOC defined "subterfuge" as a "disability-based disparate treatment that is not justified by the risks or costs associated with the disability."¹²⁴ The primary support for this interpretation is the ADA's legislative history, which states that an employee benefit plan not based on sound actuarial principles or reasonably anticipated experience constitutes subterfuge.¹²⁵ The EEOC also diverged from the *McMann/Betts* interpretation by placing the burden of proof on the defendant to show no subterfuge.¹²⁶ Plaintiffs have advocated¹²⁷ this definition of "subterfuge," which has

124. EEOC Guidance at 405:7120 (cited in note 89). Two courts have explicitly rejected this definition. In *Modderno*, the D.C. Circuit saw no difference between the ADA situation and the ADEA situation in *Betts* in which the Labor Department proffered a cost-based test that the Supreme Court rejected. *Modderno*, 82 F.3d at 1065. The court further explained that the EEOC's interpretation could not be controlling because it contradicted the plain language of the statute. *Id.* See also, *Piquard*, 887 F.Supp. at 1125 (noting that "the plain language of Section 501(c)'s 'subterfuge' sentence does not mention the risks or costs of a disability-based distinction").

125. H.R. Rep. No. 101-485, pt. 3, at 71 (cited in note 104). Moreover, in direct contradiction to the ruling in *Modderno*, the legislative history indicates that a plan can be a subterfuge regardless of the date the plan was adopted. *Id.*

126. EEOC Guidance at 405:7118-20 (cited in note 89). The EEOC reasoned that in the health insurance context the employer has the greatest access to the relevant cost information and therefore should be required to carry the burden. *Id.* At least in principle, though varying in its overall approach to section 501(c), one court has explicitly agreed with the EEOC on this matter. *Piquard*, 887 F. Supp. at 1125-26.

The EEOC also enumerated several ways in which an employer could justify a "disability-based" distinction.

The respondent may prove that the disparate treatment is justified by legitimate actuarial data, or by actual or reasonably anticipated experience In other words, . . . the disability-based disparate treatment is attributable to the application of legitimate risk classification and underwriting procedures to the increased risks (and thus increased costs to the health insurance plan) of the disability, and not to the disability per se.

The respondent may prove that the disparate treatment is necessary . . . to ensure that the challenged health insurance plan satisfies the commonly accepted or legally required standards for the fiscal soundness of such an insurance plan.

...

The respondent may prove that the challenged insurance practice or activity is necessary . . . to prevent the occurrence of an unacceptable change either in the coverage of the health insurance plan, or in the premiums charged for the health insurance plan.

EEOC Guidance at 405:7120-21 (cited in note 89) (citations omitted).

127. See, for example, *Holmes v. City of Aurora*, 1995 U.S. Dist. LEXIS 463, *14 (N.D. Ill. Jan. 17, 1995); *Doukas v. Metropolitan Life Ins. Co.*, 882 F. Supp. 1197, 1199 (1995) (stating the plaintiffs claim that the insurance practices in question "are not based on sound actuarial data and are therefore a mere subterfuge used to evade the purposes of the [ADA]"); *United States v. State of Illinois*, 1994 U.S. Dist. LEXIS 12890, *15-17 (N.D. Ill. Sept. 9, 1994) (setting forth plaintiffs' argument that a board's determination regarding a pension plan constituted "a subterfuge because it is based on stereotypical notions and myths about people with diabetes and not based on sound actuarial principles as is required by the ADA"); *Schroeder v.*

not won overwhelming approval in the district courts. A three-judge panel of the Sixth Circuit in *Parker v. Metropolitan Life Insurance Co.*,¹²⁸ a decision recently vacated but slated to be reheard en banc,¹²⁹ appeared to reject the Supreme Court's (*McMann/Betts*) definition of subterfuge, suggesting, though not explicitly alluding to, the influence of the EEOC's view.¹³⁰ The court concluded that the distinction in the plaintiff-employee's disability insurance plan between mental and physical disabilities would violate the ADA if it was not justified by "'sound actuarial principles' or 'actual or reasonably anticipated experience' or 'bona fide risk classification.'" ¹³¹ The potential underlying message is that the terms of health benefit plans may be subjected to judicial scrutiny, narrowing the 501(c) exemption further than does the *McMann/Betts* definition of subterfuge.¹³²

Under the EEOC view of subterfuge, mental illness limitations may be more vulnerable to ADA regulation. Mental health advocates could assert that limitations on mental health insurance stem from misguided perceptions or invidious bias against the mentally ill,¹³³ not the application of defensible risk classification.¹³⁴ More specifically, a

Connecticut Gen. Life Ins. Co., 18 Mental & Physical Disability L. Rptr. 554, 554 (D.D.C. 1994)) (stating the court's contention that "[j]ustifications for differential treatment are in the nature of affirmative defenses" in the context of mental illness limitation in disability benefits).

128. 99 F.3d 181 (6th Cir. 1996), vacated in 1997 U.S. App. LEXIS 2161 (6th Cir. Feb. 6, 1997).

129. *Parker v. Metropolitan Life Ins., Co.*, 1997 U.S. App. LEXIS 2161, *2 (6th Cir. Feb. 6, 1997). Though no specific grounds were given, a majority of the judges sitting on the circuit voted to rehear the case en banc. *Id.* The rehearing is scheduled for June 11, 1997. *Id.*

130. The *Parker* court explicitly disagreed with the *Modderno* court, relying on the legislative history of the ADA to construe the meaning of section 501(c). *Parker*, 99 F.3d at 192. The court first determined that section 501(c) was ambiguous on its face. *Id.* at 190.

The problem with *Parker* is that it is unclear what the true statutory basis for its conclusion is, just as it is unclear in the legislative history. Compare H.R. Rep. No. 101-485, pt. 3, at 70 (cited in note 89) (invoking "sound actuarial data" in the context of subparagraph (1) of section 501(c)), with H.R. Rep. No. 101-485, pt. 2, at 136-37 (cited in note 89) (invoking "sound actuarial principles" and "actual or reasonably anticipated experience" in the context of the subterfuge clause). At first, the decision appears to be based on the subterfuge clause, since the court rejects the *Modderno* ruling. However, the basis also appears to be in subparagraph (1) of section 501(c), not the subterfuge language, because the court states that "even if a practice did not qualify as 'evasive' under the subterfuge provision, it might still be violative of the Act if it was based on speculation, and not on sound actuarial principles, actual or reasonably anticipated experience, or bona fide risk classification." *Parker*, 99 F.3d at 192. Perhaps this confusion played a role in the decision to vacate the judgment.

131. *Parker*, 99 F.3d at 193.

132. This ruling worried employers and insurers, who feared that the continuing validity of mental illness limitations may be undermined by this interpretation of the ADA. Nancy Ann Jeffrey, *Mental-Health Ruling Alarms Employers*, Wall St. J. B10 (Jan. 22, 1997).

133. See Rubenstein, 40 St. Louis U. L. J. at 349-351 (cited in 13) (discussing the historical bias and discrimination against those with mental disabilities).

134. See Cook, 50 U. Miami L. Rev. at 362 (cited in note 13) (arguing that "the mental-physical distinction masquerades as a risk classification").

plaintiff suffering from a mental disability with a proven biological basis could assert that a distinction in her health care plan between certain biologically-based mental illnesses and "physical" diseases such as Parkinson's disease is evidence of a lack of sound principles or of stereotypical notions and has no cost-effectiveness basis when compared to treatment for illnesses such as heart disease.¹³⁵ Moreover, the common preference for inpatient treatment over less-expensive outpatient treatment may reveal a faulty cost assessment.¹³⁶ If courts agreed with these arguments, a court could find a mental illness limitation to be a "subterfuge" in violation of the ADA, requiring relief for the disabled party.¹³⁷ The question remains, however, whether such relief is the correct result under section 501(c).

4. Conclusion: No Legislative or Judicial Relief

Perhaps Judge Gilbert Merritt of the Sixth Circuit best described Congress's approach to insurance practices in the ADA when he wrote:

Unlike the language of Title III, which is quite clear, the meaning of the "safe harbor" provision is not self-evident. In fact, the statute appears to be purposefully vague in order to satisfy contending interest groups. Unable to decide on exactly what it intended to legislate, Congress inserted language which looks in two directions. One provision attempts to appease the insurance industry; the other provisions attempt to help the large group of disabled people. In doing so, Congress has again left this Court in the position to give meaning to conflicting statutory language designed as a political compromise.

We find that, in this instance, the statute is totally *ambiguous* on its face.¹³⁸

135. See note 42 (discussing Sen. Domenici's comments on the comparative effectiveness of mental health care). See also Ruhenstein, 40 St. Louis U. L. J. at 350-51 (cited in note 13) ("[W]hen measured by typical rationing criteria, such as efficacy, cost-effectiveness, or quality of life, many mental health interventions emerge quite well") (citations omitted).

136. Ramage, 45 Vand. L. Rev. at 970-71 (cited in note 16).

137. To some extent, the EEOC's view of subterfuge could transform courts into forums for the discussion and determination of public policy issues. This tendency is reflected in the fact that the proffered arguments against mental illness limitations under the ADA sound very similar to those made in the context of the MHPA. See Part II.A.2 (discussing the arguments for parity). Courts, however, have expressed a wariness about allowing this discussion to occur in this context. See *Parker*, 99 F.3d at 194 ("[I]t is not the role of the courts to write insurance policies"); *Modderno*, 82 F.3d at 1060 (refusing to entertain the plaintiff's arguments regarding "basic justice," "prudential calculus," and "social research" in the context of a challenge to a mental illness limitation).

138. *Parker*, 99 F.3d at 190. A similar sentiment was expressed in the dissenting view of Representative Chuck Douglas of New Hampshire concerning section 501(c): "Congress is

The "political" choice that courts face in defining subterfuge is intriguing. The *McMann/Betts* definition obviously favors the business community in the battle to preserve its freedom from regulatory interference with employee benefit plans. A decision to apply the EEOC definition, on the other hand, is a victory for the community of individuals suffering from disabilities.¹³⁹ The latter approach, however, relies on the "ambiguity" of the subterfuge language. This "ambiguity" was probably all too clear to Congress and the business and insurance communities when the ADA was drafted. *Parker* is thus in the distinct minority among courts interpreting the subterfuge clause. The majority of courts will probably continue to adopt the *McMann/Betts* definition. Though this may seem untenable to some judges,¹⁴⁰ Congress seems to have succeeded in preserving the ongoing parity battle for another day.

While courts could opt for far-reaching interpretations of section 501(c),¹⁴¹ they are not to blame for the ultimate lack of protection the ADA affords. Had Congress wished to subject the terms of health benefit plans to rigorous scrutiny though the use of the term "subterfuge," it should have done so more explicitly, especially in light of the Supreme Court's subterfuge precedent.¹⁴² In other words, the ADA's perceived lack of effectiveness is the result of Congress's own uncertainty. Of course, caught in the political crossfire and fearing repercussions, Congress may have purposely crafted an ambiguous statute in the hopes that the courts and administrative agencies would reach a compromise similar to that in the EEOC's Guidance, in which the ADA reaches issues such as highly controversial limits on

abrogating it [sic] constitutional duty by writing vague laws which must be clarified by the Federal courts." H.R. Rep. No. 101-485, pt. 3, at 94 (cited in note 89).

139. *Parker*, 99 F.3d at 192.

140. See *id.* at 192 ("It seems unlikely that Congress would leave the insurance industry virtually untouched by a statute that is designed to address 'the major areas of discrimination faced day-to-day by people with disabilities.'").

141. See Orentlicher, 31 Harv. C.R.-C.L. L. Rev. at 87 (cited in note 4) (stating that "judicial interpretations have given inadequate recognition to the protections embodied" in the ADA").

142. The EEOC's interpretation of subterfuge is particularly troubling when the parallels between the ADEA and the ADA are considered. Under the ADEA, the Supreme Court rejected the EEOC's cost-justification test, *Piquard*, 887 F. Supp. at 1125 (citing *Betts*, 492 U.S. at 169-75), which is remarkably similar to the EEOC's interpretation of subterfuge under the ADA. Moreover, the Supreme Court rejected the ADEA's legislative history, which asserted that benefit plans enacted prior to the enactment of the ADEA could still be a subterfuge. *Betts*, 492 U.S. at 167-68. Since the statutory term "subterfuge" seems to track a similar course in both acts, logically the term should have the same definition under the ADA as it did under the ADEA.

AIDS benefits, while leaving untouched broader distinctions, most notably the mental illness limitations.¹⁴³

In short, the mental illness limitation falls outside the scope of judicial and legislative concern under the ADA. If, however, the Sixth Circuit in its rehearing of *Parker* agrees with the D.C. and Eighth Circuits, and other circuits follow suit in foreclosing relief under section 501(c), then Congress, if it truly disagrees with the courts' interpretations, may amend the ADA and more clearly outline its intentions.

IV. FURTHER CONGRESSIONAL REFORMS: OBSTACLES, ALTERNATIVES, AND SOLUTIONS

Part IV addresses the possible future of further congressional reforms in the regulation of private mental health insurance. First, Part IV sets forth two possible characterizations of the "compromises" embodied in the MHPA and the ADA. Second, the possibility of a federal minimum mental health benefits mandate is examined, followed by an analysis of a proposed parity mandate that would extend only to severe mental illnesses. Finally, Part IV discusses managed mental health care, with an emphasis on the legislation needed to achieve parity in this setting.

A. Legislative "Subterfuge" or "Schizophrenia"?

[A] subterfuge is a scheme, plan, stratagem, or artifice of evasion.¹⁴⁴

As the MHPA and the ADA illustrate, Congress has great difficulty in making truly substantive changes to the current regulation of employee health benefit plans. This observation is not necessarily a criticism. It does, however, illustrate the real tension that exists between insurance practices and anti-discrimination efforts.¹⁴⁵ This tension necessitates compromise, which, in the context of the ADA

143. See note 89 (discussing the EEOC's interpretation of insurance limitations scrutinized under section 501(c)).

144. *United Air Lines, Inc.*, 434 U.S. at 203.

145. Indeed, certain coverage distinctions and limitations made for purposes of risk classification have been referred to as "fair discrimination." Wortham, 19 U. Mich. J. L. Ref. at 361 (cited in note 40)).

and the MHPA, can be characterized as either congressional "subterfuge"¹⁴⁶ or "schizophrenia."¹⁴⁷

Health legislation is generally characterized by initial legislative aspirations of an "access egalitarian dimension."¹⁴⁸ Concerns about the costs of reform, however, often undo these egalitarian aspirations.¹⁴⁹ The result, many times, is a law that symbolically embodies broad access goals but lacks a real statutory commitment to achieving those goals.¹⁵⁰ In this context, the terms "subterfuge" and "schizophrenia," though describing the same statutory result, denote a difference in congressional intent. Legislative "subterfuge" refers to an intentional evasion of important, but difficult issues; "schizophrenia," however, suggests no invidious intent on Congress's part, but is instead a "biologically-based," or structurally inherent, defect that results from the difficulty of coordinating and resolving the diverse political goals of the various members of Congress.

These two terms are both very fitting in the cases of the ADA and the MHPA. Generally, one's conception of the motives behind the MHPA's and the ADA's treatment of insurance practices will reflect one's choice of characterization. If characterized as "subterfuge," then the MHPA is a rather disturbing example of Congress paying lip service to an issue like parity in hopes of appearing sympathetic to the issue,¹⁵¹ but, in truth, having no real intention of making any meaningful resource commitment to that end. The long-term fear of mental health advocates is that Congress has passed the MHPA as a means of pacifying active interest groups or individual members of Congress and of suppressing the issue of equality in mental health insurance.¹⁵² Likewise, the ADA could be "subterfuge" in the sense

146. The use of the term "subterfuge" in this section should not be confused with the statutory term "subterfuge" in the ADA, as discussed in Part III.B.

147. See note 23 and accompanying text (characterizing the legislative compromise of competing interests in health care as "legislative schizophrenia"). The use of the term "schizophrenia" in this context is actually misleading. Schizophrenia is oftentimes confused with multiple personality disorder, Shannon, 24 St. Mary's L. J. at 367 n.4 (cited in note 16), which is the spirit in which the term is used in this section of this Note. The medical condition "schizophrenia," however, actually causes "poor reasoning, disconnected and confusing language, hallucinations [and] delusions," not multiple personalities. *Id.* Of course, many would argue that Congress and its actions are more accurately characterized by this true, scientific definition.

148. Blumstein, 69 Iowa L. Rev. at 1233 (cited in note 23).

149. *Id.* at 1234.

150. *Id.*

151. The Senate paid lip service to mental health parity by approving the sweeping Domenici proposal, when it was already apparent that the proposal would be defeated during conference negotiations. See note 65 and accompanying text (quoting comments made by Senator Dole after voting for the proposal to the effect that it was very problematic).

152. See Part II.C.2. (discussing potential policy implications of MHPA).

that Congress, rather than dealing with the tough issues itself, has left the task to the courts and administrative agencies in order to avoid political backlash.¹⁵³ This avoidance manifests itself as a sweeping ban on discrimination undercut by a broad statutory exemption. The exemption is then further complicated by an undefined exception, the interpretation of which is confused by legislative history contradicting the only prior possible interpretation of the language of the statutory exception.¹⁵⁴

Attributing an invidious intent to Congress, however, may be unfair, especially in light of the difficulty of the parity issue. Rectifying tensions between insurance and antidiscrimination law is a long and arduous process. Perhaps the greatest victory for mental health advocates in the battle over parity has already been won by getting the word "discrimination" applied to their cause. Insurers, however, still claim valid justification for their discriminatory underwriting practices, while mental health advocates see only attempts at rationalizing those practices.¹⁵⁵ Indeed, insurance underwriters seem to be in conflict with one another. One of the primary purposes of insurance is to spread costs among the many so that those few unfortunate ones can bear the cost of catastrophic illness.¹⁵⁶ Benefit planners and insurance companies concerned about rising costs, however, seek either to limit the chances of these risks occurring in their plans through blanket exclusions or to ameliorate the costs of those not suffering such risks by shifting them to those who do

153. See note 143 and accompanying text (suggesting that Congress may have created confusion in the ADA to avoid political repercussions).

154. See Part III.B (discussing the ADA's insurance safe harbor and the statutory term "subterfuge"). As one congressman noted:

The term 'subterfuge' is used in the ADA simply to denote a means of evading the purposes of the ADA. It does not mean that there must be some malicious intent to evade the ADA on the part of the insurance company or other organization, nor does it mean that a plan is automatically shielded just because it was put into place before the ADA was passed. Indeed, there is currently a bill moving through Congress to overturn the *Betts* decision and we have no intention of repeating a decision in the ADA with which we do not agree.

136 Cong. Rec. H4624 (July 12, 1990) (statement of Representative Edwards). See also 136 Cong. Rec. S9697 (July 13, 1990) ("It is important to note that the term 'subterfuge,' as used in the ADA, should not be interpreted in the manner in which the Supreme Court interpreted the term.") (statement of Senator Kennedy).

155. See Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. of Health Politics, Policy, & L. 287, 296 (1993) ("The numerical system, and the underwriting guidelines and rating manuals . . . have all the trappings of scientific objectivity . . . but they often seem to be based as much on social prejudices and stereotypes as on empirical knowledge.")

156. *Id.* at 290-92.

through individualized premiums.¹⁵⁷ These tensions are further accentuated in the mental health context in light of the professional and public disagreement over the cost-effectiveness of psychiatric care.

Further, though some in Congress have applied the language of discrimination to mental health coverage, the MHPA and the ADA suggest that a majority of Congress still sees a great divide between some common insurance practices, including the mental illness coverage limitation, and unlawful discrimination. In fact, the ADA's legislative history recognizes "that benefit plans . . . need to be able to continue business practices in the way they underwrite, classify, and administer risks."¹⁵⁸ In other words, continued limitation of private insurance benefits, even if "discriminatory" in some way, may need to give way to the overwhelming cost constraints that presently saddle employee benefit plans. Alternatively, this denial of benefits may represent the effect of harsh market forces, not the effects of unlawful discrimination. If a majority of Congress accepts either of these two views, any future legislative "compromises" will likely fall far short of the broad access goals these "compromises" idealistically embody, as do the MHPA and the ADA.

B. Alternatives or Potential Solutions

1. A Better Compromise: A Minimum Mandate

To solve the schizophrenia/subterfuge problem of weak parity protection, lawmakers could create a statute that guarantees some real protection for the mentally ill. A minimum coverage mandate that sets certain minimum levels for dollar caps, outpatient visits, inpatient stays, and a maximum copayment percentage would provide such protection.¹⁵⁹ Several problems exist, however, with such a proposed mandate. Minimum mandates could become the de facto maximum for mental health benefits among insurers.¹⁶⁰ Moreover, such a mandate could signal the end of federal legislative reform, thus

157. See *id.* at 293 (noting that insurers reason that "[p]eople who have diseases or serious risks to their health are in a sense getting a more valuable insurance policy than those with lesser risks, so they ought to pay more for the extra value").

158. H.R. Rep. No. 101-485, pt. 2, at 138 (cited in note 104) (emphasis added).

159. Not only would such a mandate guarantee access to a certain level of care, but it could also relieve insurers of the effects of adverse selection. See note 33 (discussing the use of minimum mandates to combat adverse selection).

160. Lambert and McGuire, 15 *J. Health Politics, Policy, & L.* at 171 (cited in note 51).

extinguishing further efforts toward full parity. The business and insurance community likely would oppose mandatory minimums from a cost perspective. Studies evaluating the effects of state insurance regulation in general have identified minimum mental health mandates as some of the most costly of these measures, reducing the affordability of health plans.¹⁶¹ Further, employers would argue that the financial burden of such mandates would fall on those with severe physical illness, since benefit reductions would be necessary in those areas in order to offset the increase in mental health benefits. In addition, the complexity of the mental health delivery system may render such simplistic legislative reform efforts, including blanket parity provisions, ineffective at providing the most needed and cost-effective treatment.¹⁶²

2. Parity for "Severe" Mental Illness

Congress could also pass legislation mandating coverage and requiring parity specifically for "severe" or "serious" mental illnesses.¹⁶³ In terms of need and fairness, such legislation may be the best possible approach. Such an approach would guarantee a higher level of care for those most in need.¹⁶⁴ Moreover, if such legislation further was limited to those severe mental illnesses with a proven biological basis, it would treat equally all biologically-based illnesses, whether "physical" or "mental."¹⁶⁵ Support for this approach appears to exist, to at least some extent, on both sides of the debate.¹⁶⁶

161. *Mental Health, Obstetrical Care Coverage Most Costly of State-Mandated Benefits on Insurance Carriers*, GAO Concludes in Report to Sen. Jaffords, 8 Health News Daily 1, 1 (Sept. 25, 1996).

162. The number of treatment possibilities and the multitude of goals that mental health care encompasses create this complexity. Creative coverage packages may be crucial to cost-effectiveness. See generally Sharfstein and Steline, 11 Health Affairs at 84 (cited in note 11); Richard G. Frank, Howard H. Goldman, and Thomas G. McGuire, *A Model Mental Health Benefit in Private Health Insurance*, 11 Health Affairs 98 (Fall 1992).

163. See, for example, Tex. Ins. Code Ann. Art. 3.51-14 (Vernon Supp. 1997); 24-A Me. Rev. Stat. Ann. § 4234-A (West Supp., 1996). The Texas statute reads in pertinent part:

The coverage offered under this article for services and benefits for the condition of serious mental illness must be at least as favorable as the coverage made available for services and benefits provided by the insuring entity for other major illnesses and must include the same durational limits, amount limits, deductibles, and coinsurance factors.

Tex. Ins. Code Ann. Art. 3.51-14 § 3. For a synopsis of the legislative experience of Texas, see Shannon, 24 St. Mary's L. J. at 390-95 (cited in note 16).

164. See Shannon, 24 St. Mary's L. J. at 373-374 (cited in note 16) (advocating differentiation between biologically-based mental illness and emotionally-based mental illness).

165. *Id.* at 397.

166. See Vatz and Weinberg, *USA Today* (Magazine) at 37 (cited in note 30) (critics of parity conceding that "mandated coverage of only severe mental illness,"... "satisfy cost consideration [and] reflect public opinion").

Congress, however, does not appear to be receptive to such legislation, as evidenced by the lack of success of Senator Domenici's "Equitable Health Insurance Coverage of Severe Mental Illness Act" proposed in 1992.¹⁶⁷

An approach limited to "severe" or "serious" mental illnesses, however, has several problems. Obviously, a large number of those who suffer from mental illness could be excluded from any coverage because their conditions are not "severe" enough to warrant care.¹⁶⁸ And if only biologically-based illnesses would merit mandatory coverage, patients would face further barriers to relief. Costs would also remain a viable concern, since those with severe mental illness, though few in number, use a high percentage of the total dollars spent on all mental health care.¹⁶⁹ The focus on the "severity" of illness could have the potential of focusing funding on the treatment of illness at its most acute stages, while effectively denying funds for cost-effective preventative care in the early stages of illness.¹⁷⁰

Another problem is defining "severe" mental illness. If legislation simply referred to "severe" or "serious" illness, the impetus for provider-payer and patient-payer disputes is apparent.¹⁷¹ An easy solution to this problem would be to specifically list the illnesses

167. S. 2696, 102d Cong., 2d Sess. (May 12, 1992), in 138 Cong. Rec. S6490-91 (May 12, 1992). Senator Domenici's bill called for coverage of "treatment of severe mental illnesses" that would be "equitable and commensurate" with coverage for physical illnesses. S. 2696 § 3(a)(2), in 138 Cong. Rec. at S6491.

In the wake of the MHPA, Senator Domenici reopened this possibility by suggesting that the next step should be congressional authorization of a study aimed at defining chemically and biologically related diseases of the brain. *VA-HUD Conferees Keep Amendments on Maternity Stay, Mental Health Parity*, 4 Health Care Policy Rep. (BNA) 1497 (Sept. 23, 1996).

168. See Boyle, 40 St. Louis U. L. J. at 445 (cited in note 31) (stating that the fear of advocates for persons with less severe mental illness is that such individuals will receive nothing when a high priority is placed on access for those with severe illness). Critics of the severe mental illness approach promote "the role of mental state in the maintenance and deterioration of good physical health," Prager and Scallet, 11 Health Affairs at 120 (cited in note 45), and fear that the biologically-based movement has minimized the suffering and potential disability caused by less severe forms of mental illness. *Id.* at 120-23.

169. See note 33 (discussing the high percentage of costs incurred by those with severe illnesses). This argument was the primary one used in opposition to the Texas legislation. Shannon, 24 St. Mary's L. J. at 392 (cited in note 16).

170. See Barbara Edwards Gelbard, *Thoughts on Disease Management in Behavioral Care: An Old Practice Becomes a New Concept—and Enters a New Field*, 16 Behavioral Health Management 8 (Sept. 19, 1996) ("[T]o the extent high-intensity [acute] care can be diverted by the use of earlier, lower-cost symptom management techniques, the total expenditure to provide care . . . can be reduced.").

171. Senator Domenici's 1992 parity bill referred only to "severe mental illnesses." S. 2696 § 3(a)(2), in 138 Cong. Rec. at S6491. This term is troubling because of the lack of guidance it gives as to the covered illnesses, particularly in light of the proven ability and willingness of providers to diagnose around such undefined terms. See note 30 and accompanying text. Perhaps Senator Domenici knew of this tendency and hoped to capitalize on it with a vague bill.

encompassed by such legislation.¹⁷² This solution, however, would be very restrictive and would give insurers a basis for excluding other mental conditions from their plans. A second possibility would be to specifically align "severe" mental illness with those illnesses that have a proven biological basis.¹⁷³ While being both restrictive and exclusionary, this approach would also be contrary to the ethical notion that the suffering of the patient, not the etiology of that suffering, should be the primary concern¹⁷⁴ and would seem to suggest that only those conditions that most closely resemble "physical" illnesses should be given equal treatment. In essence, this approach belittles the "psychological" aspects of mental illness.

Another possible approach would be to limit equality of coverage to those mental health treatments that are most closely related to traditional medical treatments, such as drug therapy and hospital stays. Some commentators, however, see such legislation as potentially undermining the parity notion, because certain unique and necessary mental health treatments may not be deemed appropriate health care benefits.¹⁷⁵ Moreover, such an approach may not be cost-effective, since nontraditional, outpatient treatments are generally less expensive than traditional ones.¹⁷⁶

3. Parity in the Managed Care Context¹⁷⁷

Though the move toward managed mental health care is already well under way,¹⁷⁸ the MHPA will likely push employers to

172. See Tex. Ins. Code Ann. art. 3.51-14, § 1 (listing schizophrenia, paranoia and other psychotic disorders, bipolar disorders, major depressive disorders, and schizo-affective disorders); Me. Rev. Stat. Ann. 24-A § 4234-A(6)(A) (listing schizophrenia, bipolar disorder, pervasive developmental disorder or autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder).

173. See note 42 and accompanying text (discussing mental illnesses with a biological basis). One commentator specifically endorses this approach. Shannon, 24 St. Mary's L. J. at 374 (cited in note 16).

174. See Boyle, 40 St. Louis U. L. J. at 453 (cited in note 31) ("The etiology of a disease is less important than the fact that a person suffers from that disease") (citation omitted).

175. Ridgely and Goldman, 40 St. Louis U. L. J. at 428 (cited in note 9). See also Sabin and Daniels, 24 Hastings Center Rep. at 10 (cited in note 29) ("[S]ome forms of mental health treatment . . . seem similar to nonprofessional forms of human support and interaction.").

176. See Equitable Health Care for Severe Mental Illnesses Act of 1993, S.2696 § 4(b)(3), 102d Cong., 2d Sess. (May 12, 1992), in 138 Cong. Rec. S6491 (May 12, 1996) (setting forth, as part of a model plan for mental health care, "[c]overage of outpatient medical management with coinsurance and provider reimbursement set on par with other medical procedures to encourage the use of *cost-effective* ambulatory treatment, including treatment in non-traditional settings") (emphasis added).

177. A full discussion of the topic of managed mental health care is beyond the scope of this Note. For a thorough discussion of the issues involved, see Boyle, 40 St. Louis U. L. J. at 437 (cited in note 31); Iglehart, 334 New Eng. J. Med. 131 (cited in note 31).

adopt managed care at an accelerated rate.¹⁷⁹ This movement has "provoked unprecedented turmoil"¹⁸⁰ for mental health providers and created a sharp conflict within the mental health community.¹⁸¹ One of the sources of this turmoil is the fear that the cost-containment focus of managed care may create restrictive access barriers to treatment—barriers that could be even more restrictive than traditional mental illness limitations.¹⁸² Though these barriers include mental illness limitations, managed care uses other techniques to limit a beneficiary's access to care. Therefore, legislation mandating "full" parity, that is, equality in monetary caps, durational limits, coinsurance rates, and deductibles, still would fail to address the ways in which managed care provides unequal treatment access to those suffering from mental illness.

Recent studies have shown the effectiveness of managed care at controlling costs.¹⁸³ Managed care controls costs by limiting the amount of services used through various monitoring and review techniques.¹⁸⁴ In theory, utilization review of this kind could eliminate arbitrary mental illness caps by supplanting them with utilization controls.¹⁸⁵ Currently, however, managed care programs commonly use such caps to limit outpatient and hospital visits.¹⁸⁶

With such utilization controls come concerns that access to care will be compromised. For example, managed care organizations frequently restrict access to care for those with severe mental ill-

178. See Boyle, 40 St. Louis U. L. J. at 437 (cited in note 31) ("By most accounts this move towards managed care, including managed mental health, is unstoppable.").

179. For a discussion of this assertion, see Part II.D.1.

180. Iglehart, 334 New Eng. J. Med. at 131 (cited in note 31).

181. This conflict is best exemplified by the 1995 campaign for president of the American Psychiatric Association. The victor, Dr. Harold I. Eist, used an anti-managed care platform to defeat Dr. Steven S. Sharfstein, a more prominent national figure. *Id.* Specifically, Dr. Eist accused Dr. Sharfstein of selling out to managed care, since the mental health facility over which Dr. Sharfstein was chief executive officer had contracted out many of its services to a managed care organization. *Id.* The election was decided by a close vote of 7762 to 7391. *Id.* at 133-34.

182. See Rubenstein, 40 St. Louis U. L. J. at 318 (cited in note 13) (referring to managed care as a potential "new method of denying access to services").

183. Iglehart, 334 New Eng. J. Med. at 131 (cited in note 31).

184. *Id.* Managed care limits the delivery of services to approved providers, reviews treatment decisions of providers ("utilization review"), and closely monitors high-cost cases. *Id.*

185. See 142 Cong. Rec. S3591 (Apr. 18, 1996) (remarks of Senator Domenici) ("The era of managed care is upon us, making tight management of patient care the norm, and artificial cost measures to reduce utilization are a thing of the past."); Arons, et al., 13 Health Affairs at 197 (cited in note 85) ("The advantage of management and payment approaches to cost control is that they do not depend on limitation of coverage.").

186. Iglehart, 334 New Eng. J. Med. at 131 (cited in note 31).

ness.¹⁸⁷ More importantly, when utilization controls are used, determinations of what care is "medically necessary and appropriate"¹⁸⁸ in managed care plans may preserve the bias and undervaluing of mental health care that mental health advocates claim inheres in mental illness coverage limitations.¹⁸⁹ Considering the rift that already exists between the mental health community and the insurance community, the reviewing of physician decisions to make these determinations is bound to be fraught with endless contention.¹⁹⁰ As a result the discrepancies that exist between mental and physical health coverage could remain at the same levels or worsen, even if mental illness limitations are eliminated.

To ensure parity in the managed care setting, legislation must require that determinations of medical necessity in the context of treatment for mental illness are made according to the same standards used for such determinations in regard to physical illness.¹⁹¹ Ideally, under this approach, the cost-effectiveness of the treatment, not the underlying illness, would be the sole determinant of whether access to care should be granted.

Several problems arise, however, when evaluating such an approach. One must question whether consistent standards and cost-

187. See *id.* ("Most managed care plans do not cover chronic mental illnesses in their standard benefits package."). Studies show, however, that a larger number of patients receive care under managed care than under traditional fee-for-service care. Boyle, 40 St. Louis U. L. J. at 444-45 (cited in note 31). In addition, a study from the U.S. General Accounting Office shows that patients are more satisfied with managed care than with fee-for-service arrangements. *Id.* at 444 (citation omitted).

188. Managed care decisions on whether to cover treatment hinges primarily on determinations of "medical necessity." Sabin and Daniels, 24 Hastings Center Rep. at 5 (cited in note 29).

189. See *id.* (noting that "[m]any insurance administrators believe that judgments about medical necessity in mental health are less precise than similar judgments in other areas of medicine"). See also Boyle, 40 St. Louis U. L. J. at 453 (cited in note 31) (noting that it has been argued "'medical necessity' and 'medically effective' . . . foster individualized if not subjective and bias-ridden interpretations").

190. See 5 Health Law Rep. (BNA) 978 (June 27, 1996) (stating that managed care companies are "practicing psychology without a license or without a shred of competence") (quoting Donald Bernstein, Director of Professional Affairs for the New Jersey Psychological Association). The concern is that case managers will interfere with the proper judgments of physicians. This concern was at the heart of a complaint the New Jersey Psychological Association filed against a managed behavioral care company. *New Jersey Psychological Association v. MCC Behavioral Care Inc.*, reported in 5 Health Law Rep. (BNA) 873 (N.J. Super. Ct. Jun 6, 1996). Among several allegations, the complaint asserts that the managed care company "substituted its judgment for that of the psychologists concerning the appropriateness of requested professional services for patients." *Id.*

191. Rhode Island has enacted legislation along these lines. R. I. Gen. Laws § 27-38.2-3 (1994) (requiring that "health insurers, when making the . . . determination of medically necessary and appropriate treatment [in the context of serious mental illness], must do so in a manner consistent with that used to make the determination for the treatment of other diseases").

effectiveness measures could be established, considering the differences that exist between the diagnosis and treatment of mental health disorders and that of other areas of medical care.¹⁹² Moreover, these cost-effectiveness measures could still retain some form of bias against the mentally ill.¹⁹³ Effective enforcement of the mandate would also be an issue, unless utilization decisions were properly disclosed to patients and a fair appeals process—short of costly litigation¹⁹⁴—were in place for challenging these decisions.¹⁹⁵

Though the problems with managed mental health care are numerous, the move to managed care is inevitable. Politically, it appears to have widespread support, as evidenced by the comments of individual lawmakers¹⁹⁶ and, more subtly, the MHPA. The mental health community itself appears to be genuinely split over the issue, while employers and insurers are attracted by its proven ability to control costs. From a legislator's perspective the most important question may not be what to do about mental illness limitations, but what to do about the unique cost controls of managed care.

V. CONCLUSION

Despite lawmakers' asserted goal of ending discrimination against the mentally ill, especially those disabled by their illness, disability-discrimination laws, particularly the MHPA and the ADA, continue to afford little relief from private insurance limitations for mental health care. While the elimination of biased insurance practices is certainly desirable, the question still remains as to what role the market should play in the shaping of health care plans. Future

192. See note 31 and accompanying text (suggesting that differences do exist between mental and physical health care). One possible solution would be for Congress to develop the guidelines for "medical necessity" in mental health care. For a discussion of models of medical necessity in mental health care, see Sabin and Daniels, 24 *Hastings Center Rep.* at 10-13 (cited in note 29).

193. In general, the measure of cost-effectiveness in health care is highly controversial and potentially loaded with biased assumptions. See Peters, 70 *Ind. L. J.* at 495-500 (cited in note 100) (discussing the faulty assumptions upon which current assessments are many times based and how these assumptions can lead to the exclusion of those persons with disabilities from access to treatment).

194. For a statistical analysis of the legal challenges that patients have brought against insurance companies in regard to their treatment decisions, see Mark A. Hall, et al., *Judicial Protection of Managed Care Consumers: An Empirical Study of Insurance Coverage Disputes*, 26 *Seton Hall L. Rev.* 1055 (1996).

195. See Redwin, 26 *Seton Hall L. Rev.* at 1044-49 (cited in note 26) (discussing the potential benefits and current limitations of due process and grievance procedures in the managed care setting).

196. See note 185 (quoting Senator Domenici).

legislative efforts must seek an acceptable middle ground that balances the market's concern over high cost and advocates' concern over restricted access. In so doing, these efforts need to allow for flexibility in private planning, while securing some guaranteed level of coverage, at least for those truly in need.

The MHPA may be a step in the right direction, provided its enactment does not chill congressional interest in the issue. The rapid evolution of the health care industry, however, may render this limited enactment fully extinct. Though advocates may be wary of the "go-slow" approach at this point, perhaps a congressional study into mental health care would be beneficial at bringing both sides closer together and clarifying the misunderstandings that persist. Specifically, a better scientific understanding of mental illnesses may provide more common ground for employees and mental health advocates.¹⁹⁷ Providing the kind of equality sought by mental health advocates will require the concerted efforts of science, politics, and society at large.

Even if traditional mental illness limitations are fully eliminated, problems for persons with mental illness will persist. Many persons suffering from mental illness will remain uninsured.¹⁹⁸ Moreover, discrimination may still persist in the managed care setting in determinations of medical necessity. Even so, managed care, despite its flaws, has the greatest potential to create a more efficient and equitable system. Regardless of the health care setting, however, conflicts between access and cost will continue to create problems for which easy answers will not appear any time soon.

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197. See note 170 (discussing the possibility of a congressionally-sponsored study into the biological bases of mental illnesses).

198. See Ramage, 45 Vand. L. Rev. at 972 (cited in note 16) (stating that many persons with mental illness lack private coverage because they are unemployed).

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