

DISCRIMINATION AND MENTAL ILLNESS: CODIFIED IN FEDERAL LAW AND CONTINUED BY AGENCY INTERPRETATION

*Joni Roach**

2016 MICH. ST. L. REV. 269

ABSTRACT

There is a long history of discrimination against individuals with mental illness in the United States. Historically, individuals who suffer from mental illness have often been subject to disparate treatment in terms of health-insurance benefits. This unfortunate tradition comes at a price, since many individuals with untreated mental illness have repeated contact with the judicial system, the hospital emergency room, and homelessness.

To combat the discrimination against mental illness in the health care system, Congress has enacted several laws; however, each of them has fallen short of establishing mental-health parity. Most recently, Congress has enacted the ACA, which provides the most comprehensive mental-health-parity legislation to date. However, HHS, the agency in charge of interpreting the ACA, has not uniformly or specifically defined key terms such as “mental illness” and “medical necessity,” which will likely result in the continued arbitrary application of mental-health-parity laws from state to state.

Although it is difficult to achieve actual insurance parity because of the inherent differences between mental and physical illnesses, HHS can take steps towards equalization by requiring insurance coverage of all illnesses and disorders listed in the most current edition of the DSM. In addition, HHS should create a uniform definition of medical necessity that allows physicians to recommend treatment based on their professional medical opinion. If individual states continue to remain split on what establishes a

* J.D. 2016, Michigan State University College of Law; B.A. 2008, Grand Valley State University. First, I would like to thank Kent Sparks and Jacquelynn Kittel for their helpful feedback and advice throughout the Note-writing process. I would also like to thank Professor Brian Kaser, my expert reader, for his time and guidance. Lastly, I would like to thank my parents, Richard and Marlene, as well as my boyfriend, Michael, for their continuous support and encouragement.

mental illness and which treatments are medically necessary, mental-health parity will never be achieved.

TABLE OF CONTENTS

INTRODUCTION	270
I. THE DEVELOPMENT OF FEDERAL MENTAL HEALTH CARE LAW.....	273
A. What Is Parity?	274
B. The History of Federal Law and the Treatment of Mental Illness.....	275
C. The Next Step in Mental-Health-Parity Legislation: The Affordable Care Act	281
II. HHS INTERPRETATION OF PARITY LAW UNDER THE ACA	284
A. HHS Interpretation of the ACA Regarding Mental Illness Coverage.....	284
B. Mental Illness—As Defined by the States	285
C. Medical Necessity—As Defined by Insurance Companies	288
III. LIMITATIONS OF THE ACA IN TERMS OF MENTAL-HEALTH PARITY	293
A. Issues with Defining Mental Illness.....	293
1. <i>Vermont</i>	294
2. <i>Nevada</i>	297
3. <i>Maryland</i>	298
B. Issues with Defining Medical Necessity.....	299
IV. RECOMMENDATIONS TO IMPROVE MENTAL HEALTH PARITY	300
A. Define Mental Illness at the Federal Level	301
B. Define Medical Necessity at the Federal Level	306
CONCLUSION	310

INTRODUCTION

In November 2009, Virginia State Senator Creigh Deeds's twenty-four-year-old son, Gus, stabbed the Senator multiple times in the head and chest.¹ Gus then committed suicide outside the family's

1. Nikki Schwab, *Creigh Deeds Tells Son's Mental Health Horror Story*, U.S. NEWS & WORLD REP. (Mar. 31, 2014), <http://www.usnews.com/news/blogs/washington-whispers/2014/03/31/creigh-deeds-tells-sons-mental-health-horror-story> [<https://perma.cc/2KHL-UJCM>]. Senator Deeds was the 2009 Democratic gubernatorial nominee of Virginia. *Id.*

home.² “For the last three years of his life, Gus Deeds struggled with bipolar disorder.”³ Today, Creigh Deeds fights to prevent future tragedies by destigmatizing mental illness and changing Virginia’s state laws.⁴

Despite the spotlight on mental illness in light of similar tragedies,⁵ 60% of adults with a mental illness received no treatment in 2012.⁶ Some sufferers do not realize that they are sick, but others simply cannot find help due to a lack of resources and mental-health professionals.⁷ In the meantime, the failure to provide treatment to the more than ten million Americans with serious mental illness has led to overburdened emergency rooms, overcrowded jails, and an abundance of untreated patients left to fend for themselves on the streets.⁸ In addition, recent studies have shown that “Americans increasingly understand mental illness to be a biological condition, rather than a moral failing.”⁹ However, Americans have become more inclined to believe that those with mental illness are violent or dangerous, which may be attributed to recent mass shootings, where the perpetrators suffered from mental illness.¹⁰

The current system¹¹ used to treat mental illness in the United States is underfunded, ineffective, and often described as discriminatory because it offers less and inferior resources for the

2. *Id.*

3. *Id.*

4. *Id.*

5. Examples of similar incidents include the shootings at Virginia Tech in 2007, at Sandy Hook Elementary School in Newton, Connecticut, in 2012, and near the University of California, Santa Barbara, in 2014. See Liz Szabo, *Cost of Not Caring: Stigma Set in Stone*, USA TODAY (June 25, 2014), <http://www.usatoday.com/longform/news/nation/2014/06/25/stigma-of-mental-illness/9875351/> [<https://perma.cc/2WUQ-F9YF>].

6. *Id.*

7. *See id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. The Substance Abuse and Mental Health Services Administration (SAMHSA) “estimates that less than half of individuals with serious psychological distress receive mental health care due to various social, financial, and systemic barriers.” RAMYA SUNDARARAMAN, CONG. RESEARCH SERV., THE U.S. MENTAL HEALTH DELIVERY SYSTEM INFRASTRUCTURE: A PRIMER (2009), <https://www.fas.org/sgp/crs/misc/R40536.pdf> [<https://perma.cc/4U6T-AFYZ>]. “While there have been advances in treatment options, the delivery system and financing mechanisms have been slow to transform and apply these findings in routine practice.” *Id.*

treatment of the mentally ill.¹² From 2009 to 2012, individual states cut \$5 billion from mental-health services along with 10% of psychiatric hospital beds.¹³ As the government eliminates services for the mentally ill, many sufferers have nowhere to go, which often leaves jail and the streets as the only options.¹⁴

Both individual and societal problems arise from the continued lack of treatment for those who suffer from mental illness.¹⁵ In 2012, 40% of people with severe mental illness received no treatment.¹⁶ According to the National Institute of Mental Health (NIMH),¹⁷ people suffering from mental illness wait about ten years after symptoms appear before obtaining treatment.¹⁸ There are additional societal costs for failing to properly treat mental illness, including the expenditure of criminal-justice resources.¹⁹ Untreated mental illness can progress to violence and other crimes, including self-medicating, illegal drug use.²⁰

Congress has taken steps to decrease discrimination in terms of disparate insurance coverage for the treatment of mental illnesses,²¹

12. Szabo, *supra* note 5 (stating that “[a]dvocates and experts . . . describe a system in shambles, starved of funding while neglecting millions of people across the country each year”).

13. *Id.*

14. *Id.* (explaining that “[a]s states eliminate services for the mentally ill, many fall through the cracks, landing in emergency rooms, jails, city streets or the morgue”).

15. *See id.*

16. *Id.* Schizophrenia is an example of severe mental illness. *Id.*

17. “The mission of NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure.” *About NIMH*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/about/index.shtml/> [<https://perma.cc/M27Q-UZP3>] (last visited Feb. 24, 2016).

18. Szabo, *supra* note 5.

19. *Id.* (explaining that a “[m]ajority of Americans with mental illness have frequent contact with law enforcement”).

20. Julie Sherwood, *Shedding the Stigma: Ontario County Efforts Address Mental Illness*, DAILY MESSENGER (June 29, 2014, 8:00 AM), <http://www.mpnnow.com/article/20140629/NEWS/140629655> [<https://perma.cc/4FK7-59N5>] (stating that “mental illness . . . can result in increased drug use, overcrowding in jails and, in extreme cases, violent rampages, which have garnered national attention”). For example, “[o]fficials estimate that 40 to 50 percent of the Ontario County Jail population is there as a direct or indirect result of mental illness—and drug use, as a way of self-medicating, is common.” *Id.*

21. *See infra* Part I. These steps include the creation of Medicaid and Medicare in 1965, the Americans with Disabilities Act (ADA) in 1990, the Mental Health Parity Act (MHPA) in 1996, and the Paul Wellstone and Pete Domenici

including the Affordable Care Act (ACA), which is the latest and most comprehensive step.²² However, the Department of Health and Human Services (HHS) must do more with its interpretation of the law by universally defining the key terms “mental illness” and “medical necessity” for all insurance plans that fall within the scope of the ACA to achieve actual parity between mental and physical illnesses.²³

Part I of this Note discusses the development of federal health care law in relation to the treatment of mental illness. Part II analyzes the current HHS interpretive rules of the ACA, which constitutes the latest legislative step in a long history of federal health care law. Part III analyzes the limitations of the ACA concerning mental-health parity. Finally, Part IV recommends that for the United States to achieve true parity between mental and physical illnesses, HHS must establish a specific and universal definition of the terms “mental illness” and “medical necessity.”

I. THE DEVELOPMENT OF FEDERAL MENTAL-HEALTH-CARE LAW

The push for mental-health parity has a long history in Congress and the state legislatures.²⁴ In fact, the federal government began to regulate the treatment of mental illness when it passed the Community Mental Health Centers Act (CMHC) in 1963, which resulted in the large-scale deinstitutionalization of the mentally ill.²⁵ To encourage parity in health-insurance coverage between mental and physical illnesses, Congress created the Mental Health Parity Act (MHPA)²⁶ in 1996 and the Mental Health Parity and Addiction Act (MHPAEA)²⁷ in 2008. Finally, in 2010, Congress enacted the

Mental Health Parity and Addiction Act (MHPAEA) in 2008. These acts will be discussed in depth in Part I of this Note.

22. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified at 42 U.S.C. §§ 18001-18121 (2012)).

23. See discussion *infra* Part IV.

24. Sarah Goodell, *Mental Health Parity*, HEALTH AFFAIRS (Apr. 3, 2014), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=112 [https://perma.cc/27VA-TPYF].

25. Community Mental Health Act of 1963, Pub. L. No. 88-164, tit. II, 77 Stat. 282.

26. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944.

27. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (codified as amended at 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-5 (2012)).

ACA²⁸ to completely reform the health care system in the United States.²⁹ However, despite these efforts by the legislature, those with mental illness continue to suffer from the disparate treatment that is inherent in the health care system.³⁰

A. What Is Parity?

Insurance parity³¹ for the treatment of mental illness is difficult to define.³² Much of the debate surrounding the implementation of parity is based on the issue of determining the equivalence of services between mental- and physical-health benefits.³³ For example, some treatments for mental and substance use disorders do not have an equivalent physical medical treatment.³⁴ Historically, both private and public insurance companies have offered less payment coverage for mental health care than physical health care.³⁵ Insurance benefits for mental treatment typically have their own, usually higher, copayments; are more restrictive on the number and length of treatment visits; and allow different, usually lower, annual and lifetime spending caps on coverage.³⁶

First, a comprehensive mental-health-parity law will require an insurer to provide coverage for mental illnesses.³⁷ In addition, it will prohibit insurers from implementing higher copayments and deductibles on mental treatment than physical treatment.³⁸ Lastly, a comprehensive mental-parity law will prohibit inpatient or outpatient

28. Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010) (codified at 42 U.S.C. §§ 18001-18121 (2012)).

29. See Goodell, *supra* note 24.

30. *Id.*

31. The word “parity” means “the quality or state of being equal or equivalent.” MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 901 (11th ed. 2003).

32. See Goodell, *supra* note 24.

33. *Id.*

34. *Id.* (explaining that “it is difficult to determine the medical/surgical equivalent for a rehab stay for an acute schizophrenic episode”).

35. *Id.*

36. *Id.* (concluding that “[a]ltogether, these coverage rules made mental health benefits substantially less generous than benefits for physical health conditions”).

37. Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 15-17 (2000) (explaining the general requirements of the MHPA).

38. See Goodell, *supra* note 24.

limitations to care and lifetime or annual dollar limits to mental-health benefits.³⁹

Due to the high cost of health care, the availability of insurance often dictates whether an individual can obtain necessary treatment.⁴⁰ As a result of the disparate treatment of mental illness, many individuals suffering from mental illness often go without the treatment they require, leading advocates—and even the legislature—to push for the equal treatment of mental and physical illnesses when it comes to insurance coverage.⁴¹ Congress responded to this problem by enacting the MHPA in 1996, the MHPAEA in 2008, and the ACA in 2010, which is the most expansive parity legislation to date.⁴² Although recent parity laws will increase the number of Americans who have access to insurance coverage for mental health and substance abuse treatment, critics argue that parity legislation alone is not enough to rectify the country's broken mental-health-care system.⁴³

B. The History of Federal Law and the Treatment of Mental Illness

Passed in 1963, the CMHC was the largest contributing factor for the deinstitutionalization⁴⁴ of the mentally ill in the United States.⁴⁵ Although allegedly designed to keep the mentally ill out of the deplorable conditions present in state mental hospitals, the legislature largely supported the CMHC as a cost-saving measure.⁴⁶ Tax money saved from deinstitutionalization was never spent on the

39. See Morrison, *supra* note 37, at 17.

40. See Goodell, *supra* note 24.

41. *Id.*

42. *Id.*

43. *Id.* (citing issues such as the supply and availability of mental-health providers, determining equivalence of mental- and physical-health services, and individuals who have insurance plans not covered by the ACA).

44. Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 53-54, 59 (2011) (defining “deinstitutionalization” as a “dramatic reduction in mental hospital populations in the 1960s and 1970s”).

45. *Id.* at 53-54 (explaining that the program was designed to drop the number of mentally ill patients in custodial care by 50%, but the number of persons institutionalized in state mental-health facilities actually declined by 75% from 1955 to 1980).

46. Ralph Slovenko, *The Hospitalization of the Mentally Ill Revisited*, 24 PAC. L.J. 1107, 1115-16 (1993). In fact, “[t]he community mental health program was sold to legislators on the basis of saving money.” *Id.* at 1116.

mentally ill in the community.⁴⁷ As a result, individuals discharged from the closing state hospitals, many suffering from severe mental illness, received little to no follow-up care, resulting in the increase of mentally ill persons becoming homeless and incarcerated.⁴⁸

In 1965, Congress created Medicaid, part of the Social Security Act, as a federal assistance program designed to aid the elderly and disabled with insufficient income for necessary medical costs.⁴⁹ Ultimately, Medicaid provides states that participate in the program with the necessary funding to cover the medical costs for those who qualify.⁵⁰ However, the Medicaid program contains an exclusion regarding Institutions for Mental Disease (IMD).⁵¹ This exclusion prohibits the use of federal Medicaid dollars for the care of non-elderly, mentally ill adults in IMDs.⁵² For example:

If an individual twenty-one through sixty-four years of age resides in an IMD, that individual is excluded from benefits under the Medicaid Program. If that same individual moves from the IMD to a non-IMD facility, that person would no longer be excluded from the Medicaid

47. *Id.* at 1117.

48. E. FULLER TORREY, *ROLE OF FEDERAL GOVERNMENT'S ATTEMPTS TO IMPROVE SERVICES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS* (n.d.), <http://mentalillnesspolicy.org/media/eft/GovernmentSpendingSMIFullerTorrey.pdf> [<https://perma.cc/NM6K-9Y8P>] (emphasizing that “[p]rior to 1963 states were held responsible for the quality of [public mental illness] services; since 1963 nobody claims responsibility”).

49. Susan M. Jennen, Case Note, *The IMD Exclusion: A Discriminatory Denial of Medicaid Funding for Non-Elderly Adults in Institutions for Mental Diseases*, 17 WM. MITCHELL L. REV. 339, 340 (1991). Medicaid is a “federal assistance program for ‘aged, blind, and disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical, . . . rehabilitative, and other [services].’” *Id.* (quoting 42 U.S.C. § 1396 (1988)).

50. *Id.* at 340-41 (explaining that “[b]y setting out a ‘state plan,’ participating states are allowed to determine, to a certain degree, eligibility requirements and services to be provided”).

51. *Id.* at 344-45 (explaining that “[u]nlike the other classifications, IMD is used only for the purposes of excluding certain individuals from Medicaid eligibility”). The regulation states:

Institution for mental diseases means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

42 C.F.R. § 435.1010(2) (2012).

52. Jennen, *supra* note 49, at 346.

Program. At the same time, an individual under twenty-one or over sixty-four years of age, residing in an IMD, is not excluded from Medicaid Program benefits.⁵³

Since Medicaid coverage usually requires documentation proving low income, it is unlikely that most Medicaid beneficiaries would be able to pay for the complete cost of care in an IMD or small residential facility, even though those types of facilities may be able to provide better mental-health treatment in specific cases.⁵⁴ Medicare, also enacted in 1965, is a health-insurance program for people ages sixty-five and older.⁵⁵ It also limits the amount of insurance coverage available for mental-illness treatment by limiting the amount of time that patients can receive inpatient psychiatric care to 190 days.⁵⁶ As a result, Medicare will not cover long-term custodial support of the mentally ill.⁵⁷

In 1990, Congress created the ADA⁵⁸ to bar discrimination against those who suffer from a disability in employment, public services and accommodations, health insurance, and a variety of other areas.⁵⁹ Although textually the ADA appears to apply to both physical and mental disabilities, several courts, including the United States Supreme Court, have curtailed the ADA's strength regarding

53. *Id.*

54. *Id.*

55. SOC. SEC. ADMIN., MEDICARE 4 (2014), <http://www.ssa.gov/pubs/EN-05-10043.pdf> [<https://perma.cc/P4G2-6BBJ>]. In addition, "Medicare now insures the long-term disabled, those who require renal dialysis, and certain other persons who may buy into the program regardless of age." BARRY ALEXANDER ET AL., FUNDAMENTALS OF HEALTH LAW 84 (5th ed. 2011).

56. JUDITH R. LAVE & HOWARD H. GOLDMAN, MEDICARE FINANCING FOR MENTAL HEALTH CARE 21 (1990), <http://content.healthaffairs.org/content/9/1/19.full.pdf> [<https://perma.cc/GC5P-76WS>].

57. *Id.* (explaining that this "limit assures that Medicare will not pay for the long-term custodial support of the mentally ill"). "[B]eneficiaries with severe chronic mental illnesses, including chronic schizophrenia and affective disorders, would easily exceed 190 inpatient days over their lifetime . . ." Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 4 (2012).

58. The ADA "provide[s] a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1) (2012).

59. Sarah Ritz, *The Need for Parity in Health Insurance Benefits for the Mentally and Physically Disabled: Questioning Inconsistency Between Two Leading Anti-Discrimination Laws*, 18 J.L. & HEALTH 263, 267 (2004). In her analysis of the text of the ADA, Ritz states that "[t]he text of the ADA appears to disallow disparity in health insurance benefits between the mentally and physically disabled." *Id.* at 278.

the protection of those with mental illness.⁶⁰ In addition, several federal circuit decisions⁶¹ “have destroyed what little protection is provided to persons with mental-health disabilities” under the ADA.⁶² For example, in *Weyer v. Twentieth Century Fox Film Corp.*,⁶³ the Ninth Circuit held that there is no discrimination under the ADA so long as the disparity in health benefits is applied to all employees.⁶⁴ The court reasoned that historically, insurers have consistently distinguished between mental and physical disorders when offering health and disability benefits; therefore, it was permissible for this insurance company to continue to do so.⁶⁵

To combat some of the issues concerning insurance parity and the disparate coverage for mental-health treatment, Congress passed the MHPA in 1996.⁶⁶ Essentially, the MHPA regulates the lifetime and annual spending limits applied to mental-health-treatment

60. *Id.* at 267. Ritz explains that in general, the Supreme Court has been successful in weakening the ADA. *Id.* In 1999, “the Court adopted a narrow understanding of the class protected by the ADA [and in] 2001 [it] held that the ADA’s employment title was not valid legislation under section 5 of the Fourteenth Amendment.” *Id.*

61. See *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1102 (10th Cir. 1999) (holding that it was far different for an insurance plan to distinguish between different types of disabilities—in this case, mental versus physical—than it was to treat an employee differently from others because of her disability); *Rogers v. Dep’t of Health & Envtl. Control*, 174 F.3d 431, 432, 437 (4th Cir. 1999) (holding that the ADA only prohibited discrimination among individuals in the same class with the same risk and that mental disability and physical disability coverage involves distinct risks and hazards); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608-10 (3d Cir. 1998) (holding that there is no requirement for parity of mental-health-treatment benefits because equal coverage for all disabilities was not a requirement of the ADA); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006, 1015 (6th Cir. 1997) (holding that the ADA only prohibits discrimination between the disabled and the non-disabled, not between various disabilities); *EEOC v. CAN Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir. 1996) (holding that an insurance plan’s distinction between coverage for treatment of mental and physical illnesses was not a violation of the ADA because the Act did not contain sufficient language for a court to make a reasonable determination on the issue of mental- and physical-health parity because the controversy was still a matter of legislative debate).

62. Ritz, *supra* note 59, at 281.

63. 198 F.3d 1104 (9th Cir. 2000). In *Weyer*, the plaintiff, unable to work because of severe depression, sued her employer and her employer’s insurance carrier because the insurance policy only covered care for mental illness for twenty-four months, while allowing benefits for physical disabilities until the individual reached the age of sixty-five. *Id.* at 1107-08.

64. *Id.* at 1116.

65. *Id.*

66. Tovino, *supra* note 57, at 35-36.

benefits imposed by certain group-health-insurance plans,⁶⁷ but only if the plan offers benefits for both physical and mental health.⁶⁸ Furthermore, as enacted, the MHPA did not apply to individual health plans, Medicare, Medicaid, or any self-funded plan where the sponsor opted out.⁶⁹ As enacted, the MHPA was not a complete or successful mental-health-parity law.⁷⁰ In fact, nothing in the MHPA required an insurance plan within its scope to provide mental-health benefits.⁷¹ It did not offer any protection to individuals with substance-abuse problems, but even more problematic, it did not require actual mental-health parity because it did not require parity in terms of deductibles, copayments, day limitations for inpatient care, or visit limitations for outpatient care between mental- and physical-health benefits.⁷² Despite Congress's good intentions in enacting the MHPA, it did not actually establish comprehensive mental-health parity.⁷³

To combat some of the failings in the MHPA, Congress enacted the MHPAEA in 2008.⁷⁴ The MHPAEA expanded the MHPA by establishing a parity requirement on health plans within its scope.⁷⁵ The MHPAEA required that the costs⁷⁶ and treatment limitations⁷⁷ that group health plans imposed on mental and substance abuse treatment be no more restrictive than the costs and limitations imposed on physical health benefits—essentially requiring parity between mental and physical treatments.⁷⁸ The MHPAEA especially offered benefits to those who suffered from

67. *Id.* at 36. “As originally enacted, MHPA only regulated insured and self-insured group health plans of non-small employers, defined as those employers that employ an average of 51 or more employees.” *Id.*

68. *Id.*

69. *Id.*

70. *Id.* at 36-37.

71. *Id.* at 36.

72. *Id.* at 37.

73. *See id.*

74. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3765, 3881-93 (codified as amended at 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)).

75. Tovino, *supra* note 57, at 37-38.

76. *Id.* at 38. “[I]ncluding deductibles, copayments, coinsurance and other out-of-pocket expenses . . .” *Id.*

77. *Id.* “[I]ncluding inpatient day and outpatient visit limitations . . .” *Id.*

78. *Id.* (explaining “that covered group health plans imposed on mental health and substance use disorder benefits to be no more restrictive than the predominant financial requirements and treatment limitations imposed on substantially all physical health benefits”).

substance abuse problems.⁷⁹ In addition, an interim final rule⁸⁰ clarified questions left open by both the MHPA and MHPAEA in favor of patients suffering from mental-health conditions.⁸¹ The rule stated that a covered group health plan could not impose different accumulating costs or treatment limitations on mental health and substance abuse disorder benefits.⁸² The rule also concluded that a plan could not impose a non-quantitative treatment limitation, such as a medical-necessity limitation or an experimental limitation, on mental health and substance abuse disorder benefits.⁸³ Overall, the MHPAEA was successful in establishing some mental-health-parity requirements and increasing access to mental-health treatments for some individuals.⁸⁴

However, like the MHPA, the MHPAEA also suffered from inherent drawbacks regarding mental-health parity.⁸⁵ Similar to the MHPA, the MHPAEA did not require a health insurance plan to provide any benefits for mental-health treatment.⁸⁶ In addition, it only pertained to group health plans of “non-small employers”⁸⁷ and did not apply to any small group or individual health plans, plans under Medicaid or Medicare, or any self-funded plans whose sponsor opted out.⁸⁸ Thus, although the MHPAEA made improvements to federal law concerning mental-health parity, it fell short of requiring

79. *Id.* at 39.

80. See OFFICE OF THE FED. REGISTER, A GUIDE TO THE RULEMAKING PROCESS (2011), https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf [https://perma.cc/Y793-8RH8]. The interim final rule states:

When an agency finds that it has good cause to issue a final rule without first publishing a proposed rule, it often characterizes the rule as an “interim final rule,” or “interim rule.” This type of rule becomes effective immediately upon publication. In most cases, the agency stipulates that it will alter the interim rule if warranted by public comments. If the agency decides not to make changes to the interim rule, it generally will publish a brief final rule in the *Federal Register* confirming that decision.

Id. The rule was co-released on February 2, 2010, by the Departments of Treasury, Labor, and Health and Human Services. See Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Penalty and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (Feb. 2, 2010).

81. Tovino, *supra* note 57, at 39.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.* at 38 (stating that non-small employers are those that average fifty-one or more employees).

88. *Id.*

complete parity for most individuals with private or public insurance coverage.⁸⁹

Two years after the enactment of the MHPAEA, Congress enacted the ACA in 2010, which expanded both the MHPA and the MHPAEA.⁹⁰ Although the ACA is well known for its controversial health-insurance mandate for individuals, it also contains provisions that greatly expand parity law for mental-health benefits.⁹¹ In addition, it creates mandatory health benefits for mental health and substance abuse disorders for more individuals.⁹²

C. The Next Step in Mental-Health-Parity Legislation: The Affordable Care Act

By enacting the ACA, Congress intended to improve access to affordable health-insurance coverage and treatment, including treatment for mental illness.⁹³ The ACA particularly aims to increase access to health insurance (which includes mental-health benefits), expand the quality and delivery of health care services, and enhance mental-health results.⁹⁴ For instance, the ACA contains provisions that expand parity law and require mandatory mental health and substance abuse benefits for more individuals with both public and private health insurance.⁹⁵ Ultimately, these two provisions prohibit health insurance plans that were previously exempt from the MHPA and the MHPAEA from offering fewer benefits for mental-health treatment.⁹⁶ This includes a prohibition on higher deductibles, higher

89. *See id.*

90. *Id.* at 39-40.

91. *Id.* at 40.

92. *Id.*

93. *See* Jasmine E. Harris, *Cultural Collisions and the Limits of the Affordable Care Act*, 22 AM. U. J. GENDER SOC. POL'Y & L. 387, 412-13 (2014).

94. *Id.* ("These three areas of reform are interdependent. Improved health outcomes largely depend on the ACA's success in the first two stages of improving access and quality of health care delivery.")

95. Tovino, *supra* note 57, at 40. Professor Tovino notes:

The dramatic effect of [one] provision is to expand the application of MHPA and MHPAEA from just large group health plans to all qualified health plans that are offered on one of the new ACA-created state or regional health insurance exchanges beginning on or after January 1, 2014. A second provision buried within ACA makes conforming and technical changes . . . to clarify the expansion of MHPA and MHPAEA to individual health insurance coverage.

Id.

96. *Id.*

copayments, and lower inpatient and outpatient treatment limitations.⁹⁷ Another important provision prohibits health insurance plans from implementing lifetime or annual limits on essential health benefits (EHB) for any beneficiary of the plan.⁹⁸

Under the ACA, federal law, for the first time, requires mental health and substance abuse treatment benefits in some plans; however, there are some limitations to the ACA.⁹⁹ The ACA does not require grandfathered health plans¹⁰⁰ to provide EHBs, meaning that these health insurance plans will continue to be governed by the MHPA and MHPAEA, which do not require any mental health or substance abuse treatment benefits.¹⁰¹ A grandfathered plan “is a group health plan or health insurance issuer that was in effect on March 23, 2010, the day President Obama signed [the ACA] into law.”¹⁰² As a result, many individuals covered by both public and private health insurance programs will not benefit from the ACA’s required mental-health-parity and substance abuse treatment benefits.¹⁰³ However, grandfathered plans can lose their grandfathered status under certain conditions, including increases in deductibles and copayments, so they may ultimately disappear.¹⁰⁴

97. *Id.*

98. *Id.* at 41 (“Although ACA reserves the right of a group health plan or health insurance coverage to impose annual and lifetime per beneficiary limits on specific covered benefits that are not essential health benefits, mental health and substance use disorder benefits, including behavioral health treatments, are considered essential health benefits and thus are excepted from the right of reservation. This third ACA provision builds on the original MHPA, which allowed lifetime and annual limits but only so long as such limits that applied to treatment of mental-health conditions were not lower than those that applied to treatment of physical health conditions.”).

99. *See id.* at 42.

100. *Id.* These plans include “the exchange-offered qualified health plan, the non-exchange individual health plan, the non-exchange small group health plan, the Medicaid benchmark plan, the benchmark-equivalent plan, and the Medicaid state plan settings.” *Id.*

101. *Id.* at 44.

102. *Id.* at 42.

103. *Id.* at 44 (stating that “[l]arge group health plans not offered on a health insurance exchange, self-insured . . . plans, and . . . multiemployer welfare arrangements also are exempt from the essential health benefits requirement”).

104. *Id.* at 43. Professor Tovino states:

Activities that will cause a grandfathered plan to lose grandfathered status include: (1) the elimination of all or substantially all benefits to diagnose or treat a particular condition; (2) any increase in a percentage cost-sharing requirement; (3) certain increases in fixed-amount cost-sharing requirements, including deductibles and out-of-pocket limits but not

With the enactment of the ACA, Congress has taken substantial action toward achieving actual mental-health parity.¹⁰⁵ The ACA expanded the scope of the MHPA and MHPAEA, which allowed more individuals to access insurance coverage for mental-health treatment.¹⁰⁶ However, even with the benefits of the ACA, many individuals may still contend with difficult barriers when seeking treatment for mental disorders.¹⁰⁷

Much of the debate regarding mental-health parity centers on the belief that insurance benefits should be equal for both physical and mental illnesses.¹⁰⁸ Historically, in the United States, health insurance companies have paid less or even refused to cover treatment for mental illness.¹⁰⁹ Even Medicaid and Medicare offer fewer benefits for mental illnesses than physical illnesses.¹¹⁰ As a result, many individuals suffering from mental illness have gone without necessary treatment, resulting in homelessness, criminal activity, and drug use.¹¹¹ Congress has attempted to cure this discrepancy by enacting the MHPA, the MHPAEA, and most recently, the ACA.¹¹² Although the ACA offers the most comprehensive legislation concerning mental-health parity, HHS's failure to specially define the terms "mental illness" and "medical necessity" in the ACA will likely lead to the continuation of the disparate treatment of individuals suffering from mental illness.¹¹³

copayments; (4) certain increases in fixed-amount copayments; (5) certain decreases in contribution rates by employers and employee organizations; and (6) certain changes in annual limits.

Id.

105. *See id.* at 40.

106. *Id.*

107. Gary Fields & Jennifer Corbett Dooren, *For the Mentally Ill, Finding Treatment Grows Harder*, WALL ST. J. (Jan. 16, 2014, 4:15 PM), <http://online.wsj.com/articles/SB10001424052702304281004579218204163263142>.

108. *See* Goodell, *supra* note 24.

109. *See* *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116 (9th Cir. 2000) (holding that there is no discrimination under the ADA as long as the disparity in health benefits applied uniformly to all employees by stating that health insurers have "historically and consistently made distinctions between mental and physical illnesses in offering health and disability coverage").

110. *See* Jennen, *supra* note 49, at 740-41.

111. *See* Szabo, *supra* note 5.

112. *See supra* note 21 and accompanying text.

113. *See* Aubrey Chamberlin, Note, *Stop the Bleeding: A Call for Clarity to Achieve True Mental Health Parity*, 20 WIDENER L. REV. 253, 267 (2014).

II. HHS INTERPRETATION OF PARITY LAW UNDER THE ACA

To be covered by any insurer, a condition must be identified as an “illness” or “condition” deleterious to health, and the treatment must be determined to meet the program’s “medical necessity” criteria.¹¹⁴ The ACA is greatly limited in terms of mental-health parity by the lack of a specific definition of “mental illness” and “medical necessity.”¹¹⁵ On November 19, 2013, the departments of the Treasury, Labor, and HHS issued final regulations to reflect changes to the mental-health-parity requirements made to the MHPAEA by the ACA.¹¹⁶ However, the regulations failed to specifically define what mental-health conditions or illnesses should be covered by insurance plans governed by the ACA.¹¹⁷ Thus, such determinations were left to the states and individual insurance companies.¹¹⁸ Because HHS is essentially allowing the states to decide which mental-illness treatments to cover, the disparate treatment of those who suffer from mental illness will likely continue.¹¹⁹

A. HHS Interpretation of the ACA Regarding Mental Illness Coverage

The ACA extended the MHPAEA to individual health insurance plans.¹²⁰ The ACA also requires that the personal health insurance plans purchased through the state-run health care exchanges offer coverage for both mental illnesses and substance addiction at the same rate—or in parity—as coverage for physical illnesses.¹²¹ Starting in 2014, health care plans offered within the

114. E. Haavi Morreim, *Quality of Life: Erosions and Opportunities Under Managed Care*, 28 J.L. MED. & ETHICS 144, 146 (2000) (arguing that many of the problems with insurance coverage “stem[] from the fact that health plans standardly define their benefits coverage in terms of ‘medical necessity’”).

115. See Chamberlin, *supra* note 113, at 260.

116. Final Rules Under the Paul Wellston and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,239 (Nov. 13, 2013) [hereinafter HHS Rules].

117. Chamberlin, *supra* note 113, at 267.

118. *Id.* (explaining that HHS “Secretary Sebelius gave each state the authority to choose an existing insurance plan to act as a specific benchmark for provided services”).

119. *Id.*

120. *Id.* at 266.

121. *Id.*

state exchanges must provide a package of ten EHBs, which include mental health and substance abuse services.¹²²

HHS's Final Rule regarding EHBs confirmed that "the EHB requirement will have to comply with the MHPAEA," but "mental illness" is not specifically defined.¹²³ For instance, the applicable provision of the Rule states that

Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).¹²⁴

Although the rules offer some limitations to states' ability to limit insurance coverage for mental illness, the rules allow states to create their own definition of "mental illness" as long as it is "consistent with generally recognized independent standards of current medical practice."¹²⁵ HHS also declined to create a list or define the treatments that will require coverage.¹²⁶ As it currently stands, each state is given the authority to designate one existing health care plan as the standard for covered services.¹²⁷ In addition, health-care-plan providers will have to comply with the MHPAEA, the ACA, and any applicable state laws, which may require more coverage.¹²⁸ However, without a more concrete definition of "mental illness," many individuals with mental illness will continue to suffer from disparate treatment depending on where they live.¹²⁹

B. Mental Illness—As Defined by the States

Although the ACA requires that all insurance plans within its scope provide coverage for mental-health treatments, it does not specifically define "mental illness."¹³⁰ States have defined mental illness in several different ways due to the lack of direction from the federal government.¹³¹ For example, Arkansas defines "mental

122. *Id.*

123. *Id.* at 267.

124. HHS Rules, *supra* note 116, at 68,267.

125. *See id.* at 68,242.

126. Chamberlin, *supra* note 113, at 267.

127. *Id.*

128. *Id.*

129. *Id.*

130. *See id.* at 260.

131. *Id.*

illness” as all mental illnesses and disorders that are listed in the International Classification of Diseases Manual (ICD)¹³² and the Diagnostic and Statistical Manual of Mental Disorders (DSM).¹³³ On the other hand, Iowa law mandates insurance coverage for only “biologically based mental illness,”¹³⁴ which includes a list of the following: schizophrenia, bipolar disorders, major depressive disorders, schizo-affective disorders, obsessive-compulsive disorder, pervasive developmental disorders, and autistic disorders.¹³⁵ However, Iowa law excludes mental disorders such as anorexia.¹³⁶ Finally, Maryland does not specifically define “mental illness,” but provides that insurance benefits are required “only for expenses arising from the treatment of mental illnesses, emotional disorders, drug abuse, or alcohol abuse” if a health care provider deems the illness or disorder as treatable and the treatment is “medically necessary.”¹³⁷ Since states define mental illness in different ways, the availability of mental-health benefits may depend on where an individual resides.¹³⁸

Several state parity laws distinguish between “biologically based” and “non-biologically based” mental illnesses, or between “severe” and “non-severe” disorders.¹³⁹ For example, Nevada only requires insurance coverage for the treatment of six mental disorders that it defines as “biologically based” and “severe.”¹⁴⁰ This list is

132. The ICD “is the standard diagnostic tool for epidemiology, health management and clinical purposes.” *Classifications*, WORLD HEALTH ORG., <http://www.who.int/classifications/icd/en/> [<https://perma.cc/7R2V-5ELV>] (last visited Feb. 24, 2016). It is used by a variety of health care professionals to classify diseases and other health problems. *Id.* The ICD is currently in its tenth version; however, it is currently under revision, and the release date for ICD-11 is expected in 2018. *Id.*

133. The DSM “is the standard classification of mental disorders used by mental health professionals in the United States.” *DSM*, AM. PSYCHIATRIC ASS’N, <http://www.psychiatry.org/practice/dsm> [<https://perma.cc/V3GJ-2PGP>] (last visited Feb. 24, 2016). It is currently in its fifth edition. *Id.*; see also ARK. CODE ANN. § 23-99-503(6)(A) (West 2009).

134. There is no scientific basis to distinguish biologic and non-biologic mental disorders. Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL’Y, 455, 499 (2011) (explaining that “[c]urrent science shows that almost all mental health conditions and substance use disorders have been reported by scientists to have some type of basis in neurobiology”).

135. IOWA CODE § 514C.22(3) (2016).

136. *Id.*; see also Tovino, *supra* note 134, at 499.

137. MD. CODE ANN., INS. § 15-802(d)(1)(i)-(ii) (LexisNexis 2015).

138. See Chamberlin, *supra* note 113, at 261.

139. Tovino, *supra* note 134, at 499-500.

140. *Id.* at 469.

comprised of schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder.¹⁴¹ On the other hand, Idaho requires parity for individuals who suffer from one of seven “serious mental illnesses,” which include schizophrenia, paranoia, and other psychotic disorders; bipolar disorders; major depressive disorders; schizoaffective disorders; panic disorders; and obsessive-compulsive disorders.¹⁴² However, disorders such as post-traumatic stress disorder, eating disorders, and autism are often absent from these lists of “severe” and “biologically based” disorders even though there is a possibility of these disorders becoming severe, and recent research suggests that these disorders have a biological basis.¹⁴³ Even when states use a similar approach to define mental illness—such as utilizing the “severe” or “biologically-based” designation—the list of covered illnesses can diverge greatly.¹⁴⁴

There can also be differences in how two states define the same mental illness.¹⁴⁵ For instance, both Delaware and Vermont require insurance benefits for treatment of all mental disorders specified in a specific medical organization’s manual.¹⁴⁶ Delaware requires coverage of a list of nine “serious” mental illnesses that are set out in the most recent edition of the DSM.¹⁴⁷ On the other hand, Vermont mandates coverage of any “mental health condition” that is included in the current ICD’s mental-disorders section.¹⁴⁸ Although this difference might not appear to be initially significant, it may dictate when an individual can begin receiving treatment.¹⁴⁹ For example, for a diagnosis of Bipolar I disorder under the DSM-V as used in Delaware, it is necessary for the patient to have experienced a manic episode lasting at least one week.¹⁵⁰ However, Vermont’s use of the ICD-10 requires the patient to have at least two manic episodes

141. NEV. REV. STAT. § 689A.0455(2) (2014).

142. IDAHO CODE ANN. § 67-5761A (West 2006).

143. See *Tovino*, *supra* note 134, at 499.

144. See *id.* at 497-98.

145. See Chamberlin, *supra* note 113, at 261.

146. *Id.* (explaining that “[w]hile a large number of disorders will be covered under the language of such statutes, the diagnostic criteria for mental illness, and the illnesses covered, will vary depending on which organization’s manual is utilized”).

147. DEL. CODE ANN. tit. 18, § 3578(a)(3) (1999).

148. VT. STAT. ANN. tit. 8, § 4089b(b)(2) (2011).

149. Chamberlin, *supra* note 113, at 261.

150. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 123-24 (5th ed. 2013).

before diagnosis.¹⁵¹ According to the DSM-V, a manic episode may include an increase in goal-directed activity, psychomotor agitation, or excessive involvement in activities that have a high potential for disastrous consequences—such as unrestrained shopping sprees, risky sexual behavior, or irrational business investments.¹⁵² A manic episode could potentially cause irreparable social, financial, and bodily harm to an individual.¹⁵³ However, an individual in Delaware could obtain treatment after one manic episode, while an individual living in Vermont would have to experience at least two manic episodes before obtaining treatment.¹⁵⁴ Both Delaware and Vermont use an independent medical organization manual as a basis for their definition of “mental illness”; however, even medical organizations can differ in their definitions of specific mental illnesses, which may lead to disagreement as to when the criteria for a specific illness is met.¹⁵⁵

Because of the lack of a standardized definition of mental illness, whether and when an individual will receive treatment will vary depending on where that individual lives.¹⁵⁶ Even with the additional parity requirements contained in the ACA, states are likely to limit the variety of illnesses included in health care legislation in the interest of keeping costs at a minimum.¹⁵⁷ However, the legislative discrepancies do not end with the definition of “mental illness”; an additional issue with current parity legislation involves the lack of a specific, universal definition of what constitutes a “medical necessity.”¹⁵⁸

C. Medical Necessity—As Defined by Insurance Companies

The coverage standard for many individual health care plans is whether treatment for the mental illness constitutes a “medical

151. WORLD HEALTH ORG., INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS 10TH REVISION (2010), <http://apps.who.int/classifications/icd10/browse/2010/en#/F30-F39> [<https://perma.cc/V4GX-F5QV>].

152. AM. PSYCHIATRIC ASS'N, *supra* note 150, at 124.

153. *See* Chamberlin, *supra* note 113, at 261.

154. *Id.*

155. *See id.*

156. *See id.* at 263-64.

157. *Id.* at 264 (asserting that there will never be true parity between physical and mental illnesses “if insurance companies and various state legislators continue to craft their own definitions of mental illness”).

158. *See id.*

necessity.”¹⁵⁹ Similar to the problems with defining “mental illness,” HHS has not offered much guidance in terms of what constitutes a “medical necessity.”¹⁶⁰ The HHS rules interpreting the ACA vaguely define “medical necessity” as “[h]ealth care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meets accepted standards of medicine.”¹⁶¹ Furthermore, individual states and insurance companies may continue to use their own definitions of “medical necessity,” leading to disagreement among physicians, courts, and insurance companies as to what constitutes a “medical necessity.”¹⁶²

Some states, such as Oregon, simply allow insurance providers to craft their own definition of medical necessity and apply it to both physical and medical conditions.¹⁶³ However, this approach may cause issues with parity because basic treatment for physical illnesses can vary widely from an appropriate treatment for a mental illness.¹⁶⁴ Other states, such as Massachusetts, have created a broad definition, stating “medical necessity” constitutes health care “services that are consistent with generally accepted principles of professional medical practice.”¹⁶⁵

Similar to Oregon, several states,¹⁶⁶ including Alabama, Indiana, Idaho, and Texas, have not created a state definition of

159. *Id.* The final rules interpreting how the ACA affects the MHPAEA state that the “MHPAEA requires that the criteria for plan medical necessity determinations with respect to mental health or substance use disorder benefits . . . be made available . . . to any current or potential participant.” HHS Rules, *supra* note 116, at 68,247. The MHPAEA “also requires that the reason for any denial under the plan . . . [for] reimbursement or payment services with respect to mental health or substance use” benefits “must be made available on request . . . to the participant or beneficiary.” *Id.*

160. *See* Chamberlin, *supra* note 113, at 264.

161. Glossary of Health Insurance and Medical Terms, 76 Fed. Reg. 52,529 (Aug. 22, 2011).

162. Chamberlin, *supra* note 113, at 264. However, the rules do offer that benefits must “be consistent with generally recognized independent standards of current medical practice.” *Id.* (quoting 29 C.F.R. § 2590.712(a) (2012)).

163. OR. ADMIN. R. 836-053-1405 (2015).

164. *See* Chamberlin, *supra* note 113, at 265 (arguing that “[w]ithout considering the unique nature of mental-health-care services, some medically necessary treatments are not likely” to be covered under such a statute).

165. MASS. GEN. LAWS ch. 176O, § 1 (2015).

166. About thirty-three states have not created a definition of medical necessity. SARA ROSENBAUM ET AL., MEDICAL NECESSITY IN PRIVATE HEALTH PLANS: IMPLICATIONS FOR BEHAVIORAL HEALTH CARE 56-63 (2003), https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhp

mental illness, meaning that the term is typically defined in individual insurance contracts.¹⁶⁷ As a result, the determinations of which treatments constitute a “medical necessity” are made by insurers and not by physicians.¹⁶⁸ However, some private insurance companies¹⁶⁹ and a few states¹⁷⁰ have modeled their definition of “medical necessity” on the American Medical Association’s (AMA) definition, which states that “medical necessity” consists of:

Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.¹⁷¹

In fact, major national insurance companies Aetna, CIGNA, Health Net, Prudential, Anthem/WellPoint, and Humana adopted the AMA’s definition of medical necessity as part of a large settlement with over 900,000 physicians and governmental medical societies as a result of a consolidated class-action lawsuit.¹⁷² The lawsuits contended that these insurers engaged in a conspiracy to improperly deny payment to physicians by engaging in several types of improper conduct, including failure to pay for “medically necessary”

Publication 3A45C497-5056-9D20-3DAA24F165B5678A.pdf [<https://perma.cc/4QSS-C7DE>].

167. *Id.* at 1.

168. *Id.*

169. *See* CIGNA, CIGNA STANDARDS AND GUIDELINES/MEDICAL NECESSITY CRITERIA 7 (2015), <http://apps.cignabehavioral.com/web/basic/site/media/consumer/educationAndResourceCenter/medicalNecessityCriteria.pdf> [<https://perma.cc/8A8V-TU2L>]; *see also* AETNA, BEHAVIORAL HEALTH PROVIDER MANUAL 3 (2015), <https://www.aetnaeducation.com/ihhtml/application/upload/9516.pdf> [<https://perma.cc/WT2N-ECS2>].

170. *See, e.g.*, 18 DEL. ADMIN. CODE § 1300(2) (2007); FLA. STAT. § 627.732(2) (2013); ME. REV. STAT. ANN. tit. 24, § 4301-A (10-A) (2001).

171. AMA, STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION TO THE INSTITUTE OF MEDICINE’S COMMITTEE ON DETERMINATION OF ESSENTIAL HEALTH BENEFITS 3 (2011), <http://www.iom.edu/~media/Files/Activity%20Files/HealthServices/EssentialHealthBenefits/2011-JAN-13%20and%2014/Gerald%20Harmon%20Statement.pdf> [<https://perma.cc/RGE4-D8EU>].

172. *See In re Managed Care Litig.*, 298 F. Supp. 2d 1259, 1271 (S.D. Fla. 2003); Janet L. Kaminski, *Defining Medical Necessity*, CONN. GEN. ASSEMBLY (Feb. 23, 2007), <http://www.cga.ct.gov/2007/rpt/2007-r-0055.htm> [<https://perma.cc/K7Q3-6EZP>] (explaining that “[t]he settlements were approved at various times between 2003 and 2006”).

services.¹⁷³ Under the terms of the settlement, each company agreed to create a definition of “medical necessity,” modeled on the AMA definition.¹⁷⁴

On the other hand, some insurers define “medical necessity” as services, tests, and procedures that are “medically appropriate and cost-effective for the individual member.”¹⁷⁵ Similarly, Medicare provides that “no payment may be made . . . for items and services . . . [that] are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”¹⁷⁶ How an insurer defines medical necessity can have a large impact on what treatments an individual can afford.¹⁷⁷ Due to the high costs of medical care for both physical and mental disorders, whether an individual receives treatment that is deemed necessary by a physician is heavily influenced by the availability of insurance coverage.¹⁷⁸

Courts, physicians, and insurance companies often differ on the definition of medical necessity, which can lead to the denial of claims for treatment and litigation.¹⁷⁹ For example, in *Harlick v. Blue Shield of California*,¹⁸⁰ the plaintiff, suffering from extreme anorexia, checked into a residential treatment facility at 65% of her ideal body weight and required the insertion of a feeding tube.¹⁸¹ The defendant insurance company later refused payment for the plaintiff’s treatment because it was conducted at a residential facility, which was not covered by the plaintiff’s plan.¹⁸² The Ninth Circuit held that although the plaintiff’s insurance plan would not require treatment for her anorexia because the plan did not cover residential treatment, the state’s parity law¹⁸³ would require the plan to pay for the

173. Kaminski, *supra* note 172.

174. *Id.*

175. UNITED HEALTHCARE, MEDICAL NECESSITY FREQUENTLY ASKED QUESTIONS (2011), <https://www.uhctools.com/assets/M50195-B%20Member%20FAQs%20Medical%20Necessity.pdf> [<https://perma.cc/KH5Q-FMN7>].

176. 42 U.S.C § 1395y(a) (2012).

177. ROSENBAUM ET AL., *supra* note 166, at 3.

178. *Id.*

179. Chamberlin, *supra* note 113, at 264-66.

180. 686 F.3d 699 (9th Cir. 2012).

181. *Id.* at 703-04.

182. *Id.* at 705-06. The insurance company first stated that the reason for the denial of payment was based on plaintiff’s failure to prove her treatment was a medical necessity, then stated the company’s refusal was due to the fact that plaintiff’s plan did not cover any type of residential treatment. *Id.*

183. *Id.* at 710. The state’s parity law is the California Mental Health Parity Act, which was enacted in 1999. *Id.*

treatment if it was a medical necessity.¹⁸⁴ The court reasoned that, based on the language of the parity law, all health insurance plans within the scope of the parity law¹⁸⁵ must cover all medically necessary treatment for severe mental illnesses, including anorexia, under the same financial terms applied to physical illnesses.¹⁸⁶ The court deferred to plaintiff's doctors and explained that plaintiff's treatment constituted a medical necessity because her doctors believed that outpatient care was inadequate since she was only at 65% of her ideal body weight and required the insertion of a feeding tube.¹⁸⁷

The term "medical necessity" is defined in various ways by states, physicians, and insurance companies.¹⁸⁸ As a result, courts, physicians, and insurance companies may disagree as to what treatments constitute a "medical necessity," which leads to claim denials and even expensive litigation.¹⁸⁹ Without more guidance from the HHS, this disparate treatment will likely continue at the expense of mental-health-treatment access.¹⁹⁰

The ACA has extended mental-health parity to most personal-insurance plans.¹⁹¹ However, HHS, in interpreting the ACA, has not concretely defined either "mental illness" or "medical necessity."¹⁹² By leaving such important definitions to the states and insurance companies, some individuals suffering from mental illness and substance abuse disorders will continue to receive inferior treatment or no insurance benefits for treatment.¹⁹³ However, some individual state and organizational approaches are superior to others and may serve as a model for HHS when promulgating additional rules under the ACA.¹⁹⁴

184. *Id.* California has determined that a service is "'medically necessity' when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain." CAL. WELF. & INST. CODE § 14059.5 (West 2016).

185. *Harlick*, 686 F.3d at 721. In this case, it was undisputed that plaintiff's health insurance plan was within the scope of the state parity law. *Id.*

186. *Id.*

187. *Id.*

188. *See* Chamberlin, *supra* note 113, at 266.

189. *See id.*

190. *Id.*

191. *Id.*

192. *Id.* at 267.

193. *Id.*

194. *See* Tovino, *supra* note 134, at 495.

III. LIMITATIONS OF THE ACA IN TERMS OF MENTAL-HEALTH
PARITY

The ACA offers the most comprehensive protection to those suffering with mental illness to date because it expands the MHPAEA to almost all health care plans and requires that most insurance plans cover treatments for mental illness as part of the ten required EHBs.¹⁹⁵ However, because the rules promulgated by the HHS do not specially define terms such as “mental illness” or “medical necessity,” it is likely that people suffering with mental illness will not obtain actual parity because states and insurance companies will differ on how to define these terms in practice.¹⁹⁶ Because of the wide variance in state and insurer definitions of the terms, those who desperately require treatment may obtain different treatment—or even no treatment—depending on the state in which they reside even though the ACA is a federally promulgated law.¹⁹⁷

The lack of insurance coverage can have a large impact on an individual suffering with mental illness.¹⁹⁸ In general, availability of insurance heavily influences whether an individual suffering from a mental disorder will receive necessary treatment because mental-health treatments are often expensive and long term, especially in the case of chronic conditions.¹⁹⁹ As a result, coverage decisions made by insurers and state legislatures, including how “mental illness” and “medical necessity” are defined, are essential to the determination of whether individuals will have access to appropriate treatment.²⁰⁰

A. Issues with Defining Mental Illness

Although the ACA includes mental-health coverage as one of the ten necessary EHBs for insurance plans under its scope, the HHS rules interpreting the law do not offer a specific definition of “mental illness.”²⁰¹ Because of the lack of a federally promulgated definition of this key term, states and individual insurance companies have

195. Chamberlin, *supra* note 113, at 259-60.

196. *Id.* at 263-64.

197. *See id.* at 264.

198. ROSENBAUM ET AL., *supra* note 166, at 3.

199. *Id.*

200. *Id.*

201. Chamberlin, *supra* note 113, at 256 (arguing that “[c]ontrary to the intent of federal parity legislation, insurance providers continue to offer disparate coverage of mental and physical disorders due to a lack of clarity as to what constitutes a mental illness and which treatments are medically necessary”).

created their own definitions that may vary greatly.²⁰² In fact, despite the historically inferior treatment of mental illness in the United States, most individual states have created mental-health-parity laws to decrease insurance-benefit inequalities for mental illness.²⁰³ However, these state-parity laws diverge greatly in application.²⁰⁴

For instance, some state mental-health-parity laws mandate insurance coverage of almost all psychiatric or intellectual disorders.²⁰⁵ Other states have limited coverage to a short list of “traditional” disorders, which have a historical backing in medical literature and are often referenced as “biologically based” or “severe” disorders.²⁰⁶ States with statutes requiring insurance coverage of almost all psychiatric or intellectual disorders will cover all “biologically based” or “severe” disorders, in addition to many others, which means that states in the first instance provide increased access to mental-health treatments.²⁰⁷ Lastly, there are states that have created their own definition of mental illness.²⁰⁸ As a result of the widely varying approaches in defining “mental illness” by the states, the availability of insurance benefits for the treatment of mental disorders may also vary greatly based solely upon where the individual lives.²⁰⁹

1. Vermont

Vermont’s health-parity law²¹⁰ is an example of a state law requiring insurance coverage of a wide variety of mental disorders.²¹¹ It is devised to cover almost any “psychiatric, neurological, substance abuse, developmental, or intellectual disorder” that is listed in the current version of the ICD.²¹² The law aims to recognize

202. See Tovino, *supra* note 134, at 457-58.

203. *Id.* at 457.

204. *Id.* at 458.

205. See, e.g., ARK. CODE ANN. § 23-99-503(6)(A) (West 2009); VT. STAT. ANN. tit. 8, § 4089b (2011).

206. See, e.g., DEL. CODE ANN. tit. 18, § 3578(a)(3) (2007); IOWA CODE § 514C.22(3) (2005); NEV. REV. STAT. § 689A.0455 (2014).

207. See Tovino, *supra* note 134, at 457-58.

208. See, e.g., MD. CODE ANN., INS. § 15-802 (LexisNexis 2014); N.H. REV. STAT. ANN. § 417-E:1 (2011).

209. See ROSENBAUM ET AL., *supra* note 166, at 3.

210. VT. STAT. ANN. tit. 8, § 4089b.

211. See Tovino, *supra* note 134, at 458.

212. See *id.* Professor Tovino states:

Chapter V of the 10th revision of the ICD classifies dozens of mental disorders within eleven broad categories, including: (i) organic mental

treatment for mental conditions as an essential part of health care and guarantee that insurance plans cover all necessary treatments, which includes both physical- and mental-health-treatment services.²¹³ This law regulates all health insurance plans provided by private insurers as well as plans administered by the state.²¹⁴ In addition, the law requires all health insurance plans to cover treatment of a “mental condition.”²¹⁵ This type of provision makes the Vermont law a mandated-benefit law, which requires all plans to provide a mandated benefit.²¹⁶ In general, mandated-benefit laws protect plan beneficiaries from adverse selection, which in the context of mental-health benefits is the concern that plans that provide benefits for mental-health treatments will appeal to those who have more mental-health-care needs.²¹⁷ The idea is that this leads to increased costs for insurers offering mental-health benefits.²¹⁸ However, Vermont’s law reduces adverse selection concerns because all plans are required to offer mental-health benefits so one plan presumably will not appeal more to an individual who suffers from mental illness than another.²¹⁹ By mandating that all plans provide mental-health benefits, Vermont

disorders, such as Alzheimer’s disease; (ii) substance use disorders, including alcohol abuse; (iii) schizophrenia, schizotypal and delusional disorders, including paranoid schizophrenia; (iv) mood disorders, including bipolar disorder; (v) neurotic, stress-related, and somatoform disorders, including obsessive-compulsive disorder; (vi) behavioral syndromes associated with physiological disturbances and physical factors, including eating disorders; (vii) adult behavioral and personality disorders, including pathological gambling; (viii) mental retardation, including mild, moderate, and severe retardation; (ix) disorders of psychological development, including autism; (x) behavioral and emotional disorders with onset usually occurring in childhood and adolescence, including attention deficit disorder; and (xi) other mental disorders not otherwise specified.

Id. at 464-65; see WORLD HEALTH ORG., *supra* note 151, at ch. V. The eleven different mental disorder classifications range from F00-F99. *Id.*

213. VT. STAT. ANN. tit. 8, § 4089b(a).

214. *Id.* § 4089b(b)(1).

215. *Id.* § 4089b(c).

216. Tovino, *supra* note 134, at 463. Here, the mandated benefit is coverage for mental illness treatment. *Id.* Conversely, “[m]andated offer laws . . . only require health insurance plans to provide an offer, or an option, of coverage for a particular condition (here, mental illness) that the prospective insured is free to accept or reject.” *Id.* at 464. “If the insured accepts the offered benefit, the plan usually will require the insured to pay an additional or higher premium.” *Id.*

217. *Id.*

218. *Id.* (explaining that “[h]istorically, many insurers have not offered mental health benefits as a way of controlling for adverse selection”).

219. *Id.*

ensures that more individuals have access to mental-health treatment, which increases mental-health parity.²²⁰

The Vermont law also provides additional benefits and protections for individuals suffering from mental illness.²²¹ It provides that beneficiaries may only be asked to pay one combined deductible or out-of-pocket limit for both physical and mental treatments.²²² In addition, the law prevents insurance plans from excluding any authorized mental health or substance abuse providers located within the geographic area of the coverage area of the plan from the plan's network, as long as the provider meets the insurer's requirements for participation.²²³ This provision is considered an "any willing provider" provision, which prevents insurance plans from refusing to allow mental-health-care workers into their networks.²²⁴ Such a provision guarantees access to providers with mental-health expertise—and that insurers cannot agree to parity in theory only to offer a network with no authorized mental-health-care providers.²²⁵

Because Vermont requires that all insurers provide coverage for the treatment of all mental conditions listed in the current version of the ICD, an individual suffering from any of those conditions will have increased funding and access to necessary treatment.²²⁶ Vermont's parity law establishes comprehensive mental-health parity because it provides insurance coverage for a wide variety of conditions listed in an independent medical organization's manual instead of limiting coverage to a list of five or six "biologically based" or "severe" illnesses.²²⁷ Although the Vermont parity law offers extensive protection to individuals suffering from a mental disorder, other states have taken a narrower approach, especially concerning the definition of "mental illnesses."²²⁸

220. *See id.*

221. *See id.* at 465.

222. *See* VT. STAT. ANN. tit. 8, § 4089b(c) (2011) (stating that "[a] health insurance plan shall . . . make any deductible or out-of-pocket limits required under a health insurance plan comprehensive for coverage of both mental health and physical health conditions").

223. *Id.* § 4089b(c)(2).

224. Tovino, *supra* note 134, at 465-66.

225. *Id.*

226. *See* tit. 8, § 4089b(b)(2).

227. *See* Tovino, *supra* note 134, at 461.

228. *See id.* (explaining that Vermont's parity law "implement[s] comprehensive mental health parity," while the laws of Nevada "allow inferior mental health insurance benefits").

2. Nevada

The State of Nevada limits its parity laws to a list of “traditional” mental illnesses.²²⁹ These mental illnesses are usually referred to as “biologically based” or “severe” and typically include disorders such as major depression, bipolar disorder, and schizophrenia.²³⁰ However, mental disorders such as autism, post-traumatic stress disorder, and eating disorders are usually excluded from lists of “biologically based” and “severe” mental illnesses.²³¹ As a result, an individual suffering from anorexia may be unable to obtain insurance coverage for treatment simply because Nevada’s list of “biologically based” and “severe” disorders excludes anorexia.²³² The distinction between “biologically based” and “non-biologically based” mental illnesses is not supported by scientific research, and it is unclear how the “biologically based” illnesses were selected.²³³ Although Nevada’s parity law provides for the protection of those suffering from the six disorders listed in the statute, an individual suffering from a wide variety of other disorders—such as post-traumatic stress syndrome or anorexia—is offered no protection.²³⁴

Similar to the Vermont parity law, the Nevada law contains language comparable to a mandated-benefit provision because it requires an insurer to provide for the treatment of “severe mental illness.”²³⁵ However, because the Nevada law only requires coverage of the six disorders that the state has deemed to be “severe,” it may be referred to as a limited mandated law.²³⁶ In addition, in 2011, Nevada passed a provision that requires health insurance plans to offer an option—not a mandate—for coverage for screening, diagnosis, and treatment of autism-spectrum disorders²³⁷ for children

229. *See id.*

230. NEV. REV. STAT. § 689A.0455(2) (2014). Nevada’s parity law requires insurance health plans to cover the following six disorders: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, and obsessive-compulsive disorder for which diagnostic criteria are prescribed in the most recent edition of the DSM. *Id.*

231. Tovino, *supra* note 134, at 458.

232. *See id.*

233. *Id.* at 499.

234. *See id.*

235. NEV. REV. STAT. § 689A.0455(2).

236. Tovino, *supra* note 134, at 460.

237. *See* NEV. REV. STAT. § 689A.0435(1) (2015). The autism spectrum disorders include “autistic disorder, Asperger’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified.” *Id.* § 689A.0435(7)(c).

under eighteen and individuals enrolled in high school who are under the age of twenty-two.²³⁸ Although Nevada mandates insurance benefits for six “severe” mental disorders in addition to requiring an option for the coverage of autism screening and treatment for minors, it offers significantly less protection to individuals with mental illnesses than Vermont because Vermont’s parity law allows a broader application for mental-health-insurance coverage.²³⁹

3. Maryland

Finally, Maryland is an example of a state that has created its own definition of “mental illness.”²⁴⁰ Maryland’s parity statute provides that mental illnesses, emotional disorders, and drug and alcohol abuse disorders are covered if deemed treatable and medically necessary in the professional judgment of a health care provider.²⁴¹ Like Vermont’s parity statute, Maryland’s statute may be classified as a mandated-benefit law because it requires insurers to provide mental-health benefits.²⁴² However, unlike both Vermont and Nevada, Maryland does not refer to a medical manual, such as the ICD or the DSM, in its definition of “mental illness.”²⁴³ Instead, Maryland makes a broad reference to mental, emotional, and drug and alcohol abuse disorders.²⁴⁴ Although Maryland’s parity law appears to offer insurance coverage for almost any type of mental or substance abuse disorder, it is unclear whether it covers intellectual or developmental disorders, including autism, attention-deficit disorder, and mental retardation.²⁴⁵ Generally, Maryland’s parity law offers more protection for individuals with mental illness than Nevada’s limited-parity statute due to the Maryland statute’s broad definition; however, its definition of “mental illness” is less clear than Vermont’s as applied to specific intellectual or developmental disorders.²⁴⁶

Because of these differing state parity statutes, the availability of insurance coverage for the treatment of different mental disorders

238. *Id.* § 689A.0435(1).

239. *See* Tovino, *supra* note 134, at 461.

240. *See id.* at 467.

241. MD. CODE ANN., INS. § 15-802(d)(1)(i)-(ii) (LexisNexis 2014).

242. Tovino, *supra* note 134, at 467.

243. *Id.*

244. *Id.*

245. *Id.*

246. *See id.* at 461.

can vary depending on where an individual lives.²⁴⁷ The ACA is a federal law that affects health-insurance benefits in all states.²⁴⁸ However, many individuals may be unable to obtain necessary treatment due to inadequate insurance benefits because the definition of “mental illness” varies so widely from state to state.²⁴⁹ In addition, the lack of a concrete definition of “medical necessity” can also lead to the disparate treatment of those who suffer from mental illness and disagreement among physicians, insurers, and courts.²⁵⁰

B. Issues with Defining Medical Necessity

The lack of a specific federal definition of “medical necessity” may also have a substantial impact on which treatments are available for individuals suffering from mental illness.²⁵¹ The American Psychiatric Association (APA) has adopted the American Medical Association’s (AMA) definition of “medical necessity.”²⁵² However, only slightly more than one-third of states have created any statewide regulatory definition of medical necessity, which means that the term is usually defined in individual insurance contracts.²⁵³ For example, Oregon allows individual insurance companies to craft their own definitions and apply them to both physical and medical conditions.²⁵⁴ As a result, insurers, rather than medical professionals, often define which treatments are medically necessary.²⁵⁵ In addition, this approach may cause issues regarding mental-health parity because some treatments for mental illness do not have an equivalent physical medical treatment.²⁵⁶ For instance, comprehensive substance-abuse-treatment programs do not have a comparable physical treatment.²⁵⁷ It is also challenging to determine the physical

247. See *id.* at 457.

248. See Chamberlin, *supra* note 113, at 266.

249. See Tovino, *supra* note 134, at 456.

250. ROSENBAUM ET AL., *supra* note 166, at 1.

251. See Chamberlin, *supra* note 113, at 266.

252. MARTIN FLEISHMAN, *THE CASEBOOK OF A RESIDENTIAL CARE PSYCHIATRIST: PSYCHOPHARMACOSOCIOECONOMICS AND THE TREATMENT OF SCHIZOPHRENIA IN RESIDENTIAL CARE FACILITIES* (1st ed. 2005); see *infra* Section IV.B.

253. ROSENBAUM ET AL., *supra* note 166, at 1.

254. OR. ADMIN. R. 836-053-1405 (2015).

255. ROSENBAUM ET AL., *supra* note 166, at 1 (“[T]he meaning of ‘medical necessity’ is most commonly found in individual insurance contracts that are defined by the insurer and hold primacy in most determinations.”).

256. Goodell, *supra* note 24.

257. *Id.*

equivalent for the inpatient treatment of an acute schizophrenic episode.²⁵⁸ As a result, some treatments that are specific to mental illness may not be eligible for insurance coverage.²⁵⁹

Like “mental illness,” the varying definitions of the term “medical necessity” can also result in a difference in insurance coverage depending on where an individual lives or the insurance that they have.²⁶⁰ In most states, the term is defined by insurance carriers and not by actual physicians.²⁶¹ In addition, courts, insurers, and physicians often disagree on what constitutes a “medical necessity,” which may lead to an individual not receiving necessary treatment because an insurer simply denies coverage and the individual cannot otherwise afford treatment.²⁶²

The ACA offers the greatest protection to date in terms of mental-health parity, but falls short by not defining the key terms “mental illness” and “medical necessity.”²⁶³ As a result, individuals suffering from mental illness may still receive disparate treatment in terms of insurance coverage depending on where they live and the insurance company from which they receive benefits.²⁶⁴ However, although it will be difficult to achieve actual mental-health parity, HHS can take additional steps under the ACA that will greatly improve access to mental-health treatment.²⁶⁵ HHS should specifically define “mental illness” and “medical necessity” in order to increase access to mental-health treatment at the national level.²⁶⁶

IV. RECOMMENDATIONS TO IMPROVE MENTAL-HEALTH PARITY

Currently, the availability of insurance coverage for treatment depends on the state in which the individual lives.²⁶⁷ For example, a person suffering from schizophrenia would be able to obtain insurance coverage for treatment in Vermont, Nevada, and

258. *Id.*

259. *See id.*

260. ROSENBAUM ET AL., *supra* note 166, at 1.

261. *Id.*

262. *See id.*

263. *See* Chamberlin, *supra* note 113, at 259-60.

264. *See id.* at 266; ROSENBAUM ET AL., *supra* note 166, at 1.

265. *See* Tovino, *supra* note 134, at 467.

266. *See infra* Part IV.

267. *See* Tovino, *supra* note 134, at 461.

Maryland²⁶⁸ because schizophrenia is included in the ICD, Nevada's list of "severe" and "biologically based" disorders, and Maryland's broad definition of mental illness.²⁶⁹ However, a person suffering from a mental disorder, such as post-traumatic stress disorder, may only obtain treatment coverage in Vermont and Maryland because post-traumatic stress disorder is included in the ICD and Maryland's broad definition, but not in Nevada's list of "biologically based" disorders.²⁷⁰ Finally, an individual with a developmental disorder, such as autism, may only obtain treatment coverage in Vermont and Nevada because autism is included in the ICD and Nevada's 2011 provision, but it is unclear whether Maryland's statute covers intellectual disorders, such as autism.²⁷¹

Although true mental-health parity will be difficult to achieve with the vast differences between mental and physical illnesses, HHS can take additional steps to improve access to insurance coverage for mental-health services for those who are suffering from debilitating mental disorders.²⁷² By specifically defining "mental illness" and "medical necessity," HHS can improve mental-health parity and help those who are in need of help receive necessary treatment.²⁷³ Essentially, the ACA will never achieve mental-health parity without specifically defining these two terms.²⁷⁴

A. Define Mental Illness at the Federal Level

Both insurance companies and states will likely continue to define mental illness in various ways, which will result in the continued disparate treatment of those with mental illness.²⁷⁵ However, HHS should adopt a clear, useable definition of "mental illness" for all insurance plans within the scope of the ACA to improve the availability of insurance coverage to all individuals

268. Treatment would be covered as long as a health care professional deemed treatment a medical necessity. *See, e.g.*, MD. CODE ANN., INS. § 15-802(d)(1)(ii) (LexisNexis 2014).

269. *See* Tovino, *supra* note 134, at 457-58, 467.

270. *See id.* (explaining the differences in various state parity statutes). Private insurance companies, however, can provide a more comprehensive definition of mental illness in their individual plans. *See id.*

271. *See id.* at 467.

272. *See* Chamberlin, *supra* note 113, at 276.

273. *See id.*; Szabo, *supra* note 5. *See generally* Goodell, *supra* note 24.

274. *See* Chamberlin, *supra* note 113, at 276; Tovino, *supra* note 134, at 491.

275. *See* Tovino, *supra* note 134, at 457.

suffering from mental illness.²⁷⁶ To achieve this, HHS should adopt a definition of “mental illness” that includes all psychiatric or psychological conditions classified in the most current edition of the DSM.²⁷⁷

The DSM is already widely used by health care providers, insurance companies, and state parity laws.²⁷⁸ In fact, the HHS rules interpreting the ACA listed the DSM as one of the available options for states to craft their own definition of “mental illness.”²⁷⁹ The use of the current edition of the DSM to define “mental illness” will offer broad protection for individuals who suffer from mental illness because it includes all mental disorders that are currently recognized by the APA.²⁸⁰ Each disorder in the DSM includes a set of “diagnostic criteria,” which provides what symptoms must be present and for how long to qualify for a particular diagnosis.²⁸¹ The DSM also includes detailed text that outlines associated features to support the diagnosis, the prevalence of the disorder, various subtypes of the disorder, the development of the disorder, culture and gender-related diagnostic issues, and differential diagnosis.²⁸² In addition, use of the DSM increases the probability that different health care providers will diagnose the same individual identically.²⁸³

The proposed definition is similar to the approach used in Vermont’s parity law; however, the proposed definition uses the current version of the DSM as a reference manual instead of the ICD.²⁸⁴ Unlike the ICD, which includes descriptions of both physical and mental disorders, the DSM specifically concentrates on mental disorders and is the standard classification of mental disorders in the United States.²⁸⁵ Furthermore, this definition offers more comprehensive coverage than state statutes, such as Nevada’s, that only require coverage of a list of six mental illnesses that are

276. *See id.* at 503.

277. *See id.* at 491 (arguing that states should expand their parity laws “to reference the current edition of the DSM, ICD, or any other generally recognized mental illness and substance use disorder classification manual”).

278. *See DSM, supra* note 133.

279. *See HHS Rules, supra* note 116, at 68,286 (stating that mental disorder benefits must “be consistent with generally recognized independent standards of current medical practice,” then listing the DSM and ICD as examples).

280. *See DSM, supra* note 133.

281. *Id.*

282. *Id.*

283. *Id.*

284. *See VT. STAT. ANN.* tit. 8, § 4089b(b)(2) (2011).

285. *DSM, supra* note 133.

considered “biologically based” and “severe” because it offers protection of a wider range of mental disorders.²⁸⁶ Distinctions between biologically based and non-biologically based or severe and non-severe mental disorders are outdated and not supported by science.²⁸⁷ Plus, such a distinction denies insurance coverage of a variety of prevalent mental disorders.²⁸⁸ Defining “mental illness” as all conditions classified in the current edition of the DSM also offers a clear result because every covered disorder is specifically listed with appropriate diagnostic criteria, unlike state statutes such as Maryland’s, where it is unclear exactly which disorders fall under the broad, state-created definition.²⁸⁹ To achieve any sort of mental-health parity, the interpretation of the ACA should protect all individuals with psychiatric, intellectual, and developmental disorders.²⁹⁰

Critics have attacked the APA, the publisher of the DSM, for being exceedingly devoted to increasing the predominance of mental illness.²⁹¹ Furthermore, critics have also commented on the APA’s connection to the pharmaceutical industry and purported secrecy in conducting research.²⁹² However, these criticisms are not unique to the APA, the DSM, or the field of psychiatry.²⁹³ Every medical practice area has sustained concerns regarding pharmaceutical influence and research methodology.²⁹⁴ Furthermore, the APA has outlined the revision process it used to create the DSM-V.²⁹⁵ Members from organizations outside of the APA, such as the NIMH, the WHO, the World Psychiatric Association (WPA), and the American Psychiatric Institute for Research and Education (APIRE), were active in the creation of the DSM-V.²⁹⁶ From 2004 to 2008, participants from both the United States and other countries attended

286. See NEV. REV. STAT. § 689A.0455(2) (2014).

287. See Tovino, *supra* note 134, at 499.

288. *Id.* (arguing that eating disorders and autism are usually excluded from “biologically based” and “severe” disorder lists even though research shows that both disorders have a biological basis and may be severe).

289. MD. CODE ANN., INS. § 15-802(d) (LexisNexis 2014).

290. See Tovino, *supra* note 134, at 500.

291. See, e.g., Chamberlin, *supra* note 113, at 273.

292. *Id.* at 273-74.

293. *Id.* at 274.

294. *Id.*

295. See *DSM-5 Overview: The Future Manual*, AM. PSYCHIATRIC ASS’N: DSM-5 DEV., <http://www.dsm5.org/about/Pages/DSMVOOverview.aspx> [https://perma.cc/YZW7-NQGN] (last visited Feb. 24, 2016).

296. *Id.*

a total of thirteen conferences where participants addressed and wrote on specific diagnostic questions and topics.²⁹⁷ The results of most of these conferences are published in peer-reviewed journals.²⁹⁸ Furthermore, from 2007 to 2012, “work groups” reviewed the strengths and weaknesses of the DSM-IV in light of scientific advancements to develop the DSM-V’s diagnostic criteria.²⁹⁹ The final DSM-V was released in May 2013.³⁰⁰ The creation of the newest DSM-V was the result of a careful, deliberate, and reviewable process with input by individuals outside of the APA.³⁰¹ In addition, as discussed above, several states already use the DSM in their mental-health-parity statutes, and the HHS lists the DSM as one of the accepted manuals available to states to craft their own definitions.³⁰² Ultimately, the DSM is a widely used and largely accepted medical tool.³⁰³

Traditionally, insurers often claim that expanding mental-health coverage to cover more mental disorders will increase costs.³⁰⁴ However, recent research shows that general mental-health parity has a minimal effect on health care costs and, when combined with managed mental treatment, may actually produce a decrease in total costs.³⁰⁵ In fact, the research indicated that untreated mental illness might actually result in higher health care costs for individuals suffering with a mental disorder.³⁰⁶ Untreated mental illness was also found to lead to decreased work productivity, increased rates of disability, increased rates of homelessness and welfare receipt, and increased rates of criminal activity.³⁰⁷ These findings suggest that

297. *Id.*

298. *See id.* (“The results of 11 of these conferences have been published to date in peer-reviewed journals or American Psychiatric Publishing, Inc. (APPI) monographs, with the remainder of the publications anticipated in 2011 and 2012. Findings from all 13 conferences are available to serve as a substantial contribution to the research base for the DSM-5 Task Force and Work Groups and for the WHO as it develops revisions of the International Classification of Diseases.”).

299. *Id.*

300. *Id.*

301. *See id.*

302. *See DSM, supra* note 133; HHS Rules, *supra* note 116, at 68,242.

303. *See DSM, supra* note 133.

304. Tovino, *supra* note 134, at 494.

305. *Id.* (stating that the author analyzed the claim “that mental health care is more costly . . . than physical health care” and found that such a claim is not “supported in the relevant clinical, economic, social, and criminal literatures”).

306. *Id.* at 494-95.

307. *Id.* at 495.

there is a compelling societal and economic interest in treating mental illness.³⁰⁸

Another traditional argument is that compared to physical ailments, mental illnesses are too difficult to diagnose and treat.³⁰⁹ However, actual research reveals that on average, mental illnesses are not more difficult to diagnose and treat.³¹⁰ In fact, there is not a consistent or reliable testing method to distinguish between mental and physical illnesses.³¹¹ Moreover, the DSM provides a standard for diagnosing mental illnesses.³¹² For instance, each disorder in the DSM has a list of detailed diagnostic criteria.³¹³ This criterion includes necessary symptoms and the length of time they must be present, in addition to other symptoms and conditions that are required to be “ruled out” before making a specific diagnosis.³¹⁴ Not only do these criteria increase diagnostic reliability for mental illnesses, but they also increase diagnostic efficiency and validity.³¹⁵

Congress granted HHS the power to promulgate the rules governing the mental-health-parity requirements made to the MHPAEA by the ACA.³¹⁶ As a result, the rules and definitions created by HHS will apply to all health care plans governed by the ACA.³¹⁷ By creating a specific definition of “mental illness,” HHS would ensure that individuals who suffer from a mental illness would have access to the same insurance coverage regardless of the state in which they reside.³¹⁸ In addition, individual states should also adopt an identical definition in their own health-parity statutes to cover health insurance plans that do not fall under the umbrella of the ACA.³¹⁹ Furthermore, HHS should also create a definition of

308. *See id.*

309. *Id.* at 494.

310. *Id.*

311. *Id.* (“Notwithstanding judicial attempts in the context of health insurance coverage litigation to distinguish physical and mental illnesses based on tests that inquire into the area of specialization of the treating health care provider, the nature and type of treatment provided, the origin of the illness, and the symptoms of the illness, I found that not one of these tests provides a rational, consistent method of distinguishing physical and mental illness.”).

312. *DSM*, *supra* note 133.

313. *Id.*

314. *Id.*

315. *See id.*

316. *See HHS Rules*, *supra* note 116, at 68,240.

317. *See id.* at 68,257.

318. *See Tovino*, *supra* note 134, at 456.

319. *See id.* at 487 (explaining that “[b]ecause many states have mental health parity laws that are contrary to or less stringent than federal law, especially

“medical necessity” to curb disparate treatment and confusion concerning treatment coverage.³²⁰ Creating such definitions will be a beneficial next step in the process of improving mental-health parity.³²¹

B. Define Medical Necessity at the Federal Level

Similar to the term “mental illness,” the lack of a specific definition of “medical necessity” has caused disagreement between courts, physicians, and insurers.³²² Without a precise definition of the term, insurance companies, courts, and physicians may differ on which treatments constitute a medical necessity, resulting in the denial of treatment benefits and perhaps even litigation.³²³ For example, the defendant insurance company in *Harlick*³²⁴ denied the plaintiff’s claim for coverage of her residential treatment for severe anorexia because the plan did not cover residential treatment.³²⁵ Although the court agreed that the plaintiff’s treatment would not be covered by her insurance plan because it was residential treatment, it determined that the state’s parity law required coverage for any treatment that was medically necessary notwithstanding categorizations such as residential or non-residential.³²⁶ The court stated that the plaintiff’s treatment was medically necessary because her physicians did not believe that outpatient treatment, which would have been covered under the plaintiff’s plan, would have sufficed since she was 65% of her ideal body weight and required a feeding tube.³²⁷ As the facts of *Harlick* demonstrate, the lack of a uniform definition of “medical necessity” can lead to an insurer denying a claim for treatment that is recommended by a medical professional and ultimately deemed “medically necessary” by a court.³²⁸ Although the plaintiff in *Harlick* ultimately triumphed over her insurance company, other individuals suffering from severe disorders may be unable to bring legal claims against their insurers for benefit-claim

MHPAEA and ACA,” the author “propose[s] conforming changes to state mental health parity law”).

320. See Chamberlin, *supra* note 113, at 275.

321. See *id.*

322. See ROSENBAUM ET AL., *supra* note 166, at 25.

323. See *id.*

324. *Harlick v. Blue Shield of Cal.*, 686 F.3d 699 (9th Cir. 2012).

325. See *id.* at 705.

326. See *id.* at 721.

327. See *id.*

328. See *id.*

denials and will either have to forgo necessary treatment or pay for the entirety of the treatment.³²⁹

Because of these discrepancies, an insurance company may deny insurance benefits for treatment that a physician has deemed necessary.³³⁰ As a remedy for this issue, HHS should model the definition of “medical necessity” off of the AMA definition.³³¹ The AMA has defined “medical necessity” as:

Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate in terms of type, frequency, extent, site, and duration; and c) not primarily for the convenience of the patient, treating physician, or other health care provider.³³²

This definition focuses on what a “prudent physician” would conclude based on the evidence rather than the determination of an insurer.³³³ Thus, more decision-making power is returned to the provider, and the focus is on a determination of “generally accepted” medical opinions rather than the opinion of insurance professionals who may not be physicians.³³⁴ Under this definition, a “prudent physician” is able to use his or her own expertise when determining the best possible treatment for each individual patient.³³⁵ This definition deemphasizes cost and utilization, and emphasizes medical quality and clinical effectiveness, which helps strengthen the patient–physician relationship and increase access to necessary treatments.³³⁶

Critics argue that AMA’s definition of “medical necessity” is not useful when evaluating psychological services.³³⁷ This argument is based on the fact that one patient’s necessity will amount to another patient’s mere convenience.³³⁸ However, this definition emphasizes the “prudent physician” and allows that physician to

329. See Goodell, *supra* note 24. Many individuals who suffer from severe mental illness are unable to obtain and keep employment, which would make bringing a legal claim against an insurance company or paying out-of-pocket for treatment nearly impossible. See *id.*

330. See AMA, *supra* note 171, at 3.

331. See *id.*

332. *Id.*

333. See *id.*

334. See *id.*

335. See *id.*

336. See *id.*

337. See FLEISHMAN, *supra* note 252, at 206.

338. See *id.*

utilize his or her own expertise when making treatment decisions.³³⁹ Surely, a physician who has been working with a patient is in a better position to make treatment decisions than an insurance company that has never even met the patient.³⁴⁰ Moreover, the argument that one treatment may be a necessity for one patient, but only a convenience for another could also apply to treatment determinations for physical illnesses.³⁴¹ Thus, the contention that the definition is not workable for mental treatments is unconvincing.³⁴²

In addition, proper mental health care often involves input and support from the patient's family, legal representatives, and other caretakers because individuals suffering from mental illness are often unreliable.³⁴³ The current AMA definition does not expressly recognize this requirement; however, it serves as a starting point for both physicians and insurance companies.³⁴⁴ Plus, the definition does not prevent this practice.³⁴⁵ If a "prudent physician" wishes to consider information from outside sources when making a treatment determination, then this definition allows the physician to do so.³⁴⁶

There is also an argument that even with a specific and uniform definition of "medical necessity," insurance companies will continue their current coverage practices and simply ignore or decline to follow it.³⁴⁷ However, the AMA definition has been used by at least one federal court as a partial remedy for the practice of denying claims that fit into an insurer's definition of "medical necessity."³⁴⁸ Additionally, the combination of the AMA's definition of "medical necessity" and the DSM's criteria to define "mental illness" provides insurance companies with less capability to deny mental-health treatment claims.³⁴⁹

339. See AMA, *supra* note 171, at 3.

340. See *id.*

341. See Tovino, *supra* note 134, at 494 (concluding that there is no reliable way to distinguish between physical and mental illnesses).

342. See AMA, *supra* note 171, at 3 (explaining that "[t]he 'prudent physician' standard of medical necessity ensures that physicians are able to use their expertise and exercise discretion, consistent with good medical care, in determining the medical necessity for care to be provided each individual patient").

343. FLEISHMAN, *supra* note 252, at 206-07.

344. *Id.* at 206; see AMA, *supra* note 171, at 3.

345. See AMA, *supra* note 171, at 3.

346. See *id.*

347. See *supra* Section IV.A.

348. See *In re Managed Care Litig.*, 298 F. Supp. 2d 1259 (S.D. Fla. 2003); Kaminski, *supra* note 172.

349. See ROSENBAUM ET AL., *supra* note 166, at 22 (explaining that a state Attorney General's office found that insurance companies "were often denying

Individual states have traditionally regulated insurance determinations, and there is an argument that states should be able to experiment in ways to improve insurance coverage for their own citizens.³⁵⁰ However, by enacting the ACA and requiring that all insurance plans within its scope offer the ten EHBs, Congress has made it clear that it intends to manage and improve health insurance at the federal level.³⁵¹ In addition, the variety of ways in which states or insurance companies have defined “medical necessity” has led to the disparate treatment of those suffering from mental illnesses because an insurance company will simply deny a payment claim because it determined that the physician-recommended treatment was not a medical necessity.³⁵²

As discussed above, HHS has wide latitude to create the rules governing health care plans that fall under the ACA.³⁵³ If HHS adopts the AMA’s definition of “medical necessity,” then individuals will have the same access to mental-health benefits regardless of the state in which they live.³⁵⁴ Furthermore, to also cover plans that are not governed by the ACA, individual states should also adopt the AMA’s “medical necessity” definition.³⁵⁵ This will ensure uniform mental-health treatment benefits across the country.³⁵⁶

Even though the ACA has taken great strides in terms of mental-health parity, HHS could enhance the ACA’s effect by creating specific federal definitions of “mental illness” and “medical necessity.”³⁵⁷ Many individuals will gain health-insurance coverage under the ACA.³⁵⁸ However, the positive effects of the ACA are severely limited if an individual suffering from a disabling mental

authorization or reimbursement for inpatient mental health and substance abuse treatment and offering nothing more than a generic explanation that the service was “not medically necessary”).

350. See *Tovino*, *supra* note 134, at 487.

351. See *Chamberlin*, *supra* note 113, at 266.

352. ROSENBAUM ET AL., *supra* note 166, at 1 (explaining that “[e]ven where a claimant can show that a clinical recommendation is consistent with professional clinical standards, the insurer may reject a proposed treatment if it is inconsistent with other definitional elements such as relative cost and efficiency”).

353. See *HHS Rules*, *supra* note 116, at 68,240.

354. See *AMA*, *supra* note 171, at 4.

355. See *Tovino*, *supra* note 134, at 487 (explaining that “[b]ecause many states have mental health parity laws that are contrary to or less stringent than federal law, especially MHPAEA and ACA,” the author “propose[s] conforming changes to state mental health parity law”).

356. See *AMA*, *supra* note 171, at 4.

357. *Chamberlin*, *supra* note 113, at 276.

358. See *Fields & Dooren*, *supra* note 107.

illness cannot obtain insurance coverage for the treatment of a specific illness due to an arbitrary state or insurer definition of “mental illness” or “medical necessity.”³⁵⁹

CONCLUSION

Historically, individuals who suffer from mental illness have often been subject to disparate treatment in terms of health benefits in the United States.³⁶⁰ This unfortunate tradition comes at a price, since many individuals with untreated mental illness have repeated contact with the judicial system, the hospital emergency room, and homelessness.³⁶¹ To combat the discrimination against mental illness in the health care system, Congress has enacted several laws; however, each of them has fallen short of establishing mental-health parity.³⁶² Most recently, Congress has enacted the ACA, which provides the most comprehensive parity legislation to date.³⁶³

However, HHS, the agency in charge of interpreting the ACA, has not uniformly or specifically defined the key terms such as “mental illness” and “medical necessity,” which will likely result in the continued arbitrary application of mental-health-parity laws from state to state.³⁶⁴ Although it is difficult to achieve actual insurance parity because of the inherent differences between mental and physical illnesses, HHS can take steps towards equalization by requiring insurance coverage of all illnesses and disorders listed in the most current edition of the DSM.³⁶⁵ In addition, HHS should create a uniform definition of medical necessity that allows physicians to recommend treatment based on their professional medical opinion.³⁶⁶ Mental-health parity will never truly be achieved if individual states continue to remain split on what establishes a mental illness and which treatments are medically necessary.³⁶⁷

359. See Chamberlin, *supra* note 113, at 266.

360. Szabo, *supra* note 5.

361. *Id.*

362. See *supra* Part I.

363. See Tovino, *supra* note 57, at 7.

364. See Chamberlin, *supra* note 113, at 266.

365. See Goodell, *supra* note 24; Tovino, *supra* note 134, at 455-56.

366. ROSENBAUM ET AL., *supra* note 166, at 8.

367. See Chamberlin, *supra* note 113, at 276; Tovino, *supra* note 134, at 491.

physical illnesses, HHS can take steps towards equalization by requiring insurance coverage of all illnesses and disorders listed in the most current edition of the DSM.³⁶⁵ In addition, HHS should create a uniform definition of medical necessity that allows physicians to recommend treatment based on their professional medical opinion.³⁶⁶ Mental-health parity will never truly be achieved if individual states continue to remain split on what establishes a mental illness and which treatments are medically necessary.³⁶⁷

365. See Goodell, *supra* note 24; Tovino, *supra* note 134, at 455-56.

366. ROSENBAUM ET AL., *supra* note 166, at 8.

367. See Chamberlin, *supra* note 113, at 276; Tovino, *supra* note 134, at 491.



Michigan State
Law Review

Forthcoming Articles

The 2016:2 issue will include the following articles from the symposium titled *Legal Quanta* held at Michigan State University College of Law on October 29, 2015.

Legal Quanta: A Mathematical Romance of Many Dimensions

James Ming Chen

Understanding Noncompetition Agreements: The 2014 Noncompete Survey Project

J.J. Prescott, Norman D. Bishara & Evan Starr

The Success of Former Solicitors General in Private Practice: Costly and Unnecessary

Ryan C. Black & Ryan J. Owens

Is Judicial Expertise Dynamic? Judicial Expertise, Complex Networks, and Legal Policy

Anne Lippert & Justin Wedeking

Legal Networks: The Promises and Challenges of Legal Network Analysis

Ryan Whalen

Momentary Lapses of Reason: The Psychophysics of Law and Behavior

James Ming Chen

How to Ground a Language for Legal Discourse in a Prototypical Perceptual Semantics

L. Thorne McCarty

Regulation by Calculator: Experience Under the Affordable Care Act

Seth J. Chandler