

THE MENTAL HEALTH PARITY ACT: A BAR TO INSURANCE BENEFITS PARITY FOR THE ELDERLY?

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Currently, an estimated sixty-three percent of elderly Americans have an unmet need for mental health services. In this note, Brian LaFratta explores the negative impact that the Mental Health Parity Act has upon this segment of the American population as they search for adequate mental health benefits. Mr. LaFratta argues that since its implementation in 1996, the Act has barred access to mental health insurance benefits for millions of elderly Americans because of its limited scope and multiple exceptions. Among the Act's most notable exceptions is its inapplicability to the Medicare program in which ninety percent of the elderly population is enrolled. Furthermore, courts have held that the passage of the Act forecloses remedy for disparate insurance coverage under the Americans with Disabilities Act. Mr. LaFratta maintains that the Act, therefore, does not create the real parity between benefits for mental and physical illness as it was established to do and as is needed by the elderly. Therefore, he offers new legislative solutions in the form of amendments to Medicare and the ADA aimed at providing genuine parity among insurance benefits to the elderly.

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I. Introduction

Many members of the elder population suffer from mental illness.¹ Insurance coverage for psychiatric treatment, both under Medicare and private insurance, falls far short of that provided for physical illness. The result of this inequity in coverage is that large numbers of elderly Americans are deprived of needed treatment for mental illness. In light of the arguably discriminatory nature of this disparate coverage, Congress enacted the Mental Health Parity Act (hereinafter the "Act" or "MHPA") in 1996. Generally, the Act requires insurers who cover mental illness to offer equal annual and lifetime coverage capitations for mental and physical illness. However, the Act is quite limited in scope and contains many exceptions. Most notably, it does not apply to Medicare. Furthermore, passage of the Act has foreclosed remedy under the Americans with Disabilities Act (ADA) for disparate insurance coverage, heretofore the only available remedy. These limitations and consequences have essentially effected a bar to insurance benefits parity for the elderly.

Part II of this note examines the problem of mental illness in the elderly and the effect that disparity in insurance coverage has on this population. Part II also addresses the potential remedies to disparate insurance coverage that existed prior to the passage of the MHPA, the case for parity, and the provisions of the MHPA. Part III addresses the shortcomings of the Act and the resulting limitation in remedies that passage of the Act has caused. Part IV recommends fundamental changes to either the MHPA or the ADA as a means of effecting true parity in insurance coverage, or at the least, the availability of a remedy.

1. See The Virtual Office of the Surgeon Gen., *The Surgeon General's Report on Mental Health: Chapter 2* (visited Mar. 29, 2000) <<http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2.html>> [hereinafter *The Surgeon General's Report*].

II. Background

A. The Elderly, Mental Illness, and Insurance Coverage

It is currently estimated that about twenty percent of the U.S. population suffers from some sort of mental disorder.² The elderly are detrimentally affected by mental illness at a rate similar to that of the general population.³ However, statistical estimates of mental illness in the elderly may be too conservative for a variety of reasons.⁴ First, diagnostic criteria for mental illness are based on the presentation of illness in middle-aged adults.⁵ Therefore, many older adults who are experiencing the symptoms of an illness may not be diagnosed with that illness.⁶ Second, mental disorders in the elderly often coincide with other medical disorders, the symptoms of which may mask psychopathology, making diagnosis more difficult.⁷ Third, the elderly are less likely to complain of psychological symptoms than they are of somatic ones.⁸ Fourth, most medical diagnosis of the elderly is done by primary care providers, who tend to under-diagnose mental illness.⁹ Based on this, it is estimated that up to sixty-three percent of the elderly with a mental disorder have an unmet need for mental health services.¹⁰ Fifth, stereotypes about the elderly may influence relatives of the elderly into delaying medical treatment for symptoms that they believe are normal, such as senility, depression, and hopelessness.¹¹ Last, cognitive decline, whether normal or pathological, may mask the symptoms of mental illness and may make it difficult to obtain accurate patient histories.¹² All of these factors indicate that the

2. *See id.* This estimate is based on two studies: the Epidemiological Catchment Area study of the early 1980s and the National Comorbidity Survey of the early 1990s, which defines mental illness according to the Diagnostic and Statistical Manual of Mental Disorders. *See id.*

3. *See id.*

4. *See generally id.*, at ch. 5 <<http://www.surgeongeneral.gov/library/mentalhealth/chapter5/sec1.html>>.

5. *See id.*

6. *See id.* This failure to diagnose mental disorders has been considered a "serious public health problem." *Id.* (quoting National Institutes of Health Consensus Development Panel on Depression in Late Life, *Diagnosis and Treatment of Depression in Late Life*, 268 JAMA 1018, 1024 (1992)).

7. *See The Surgeon General's Report*, *supra* note 1, at ch. 5.

8. *See id.* This is due to the perceived stigma of mental illness, denial, the reluctance to fulfill stereotypes of aging, such as senility, and the belief that such symptoms are normal in the elderly. *See id.*

9. *See id.*

10. *See id.*

11. *See id.*

12. *See id.*

elderly are likely to suffer from mental illness at rates higher than previously estimated.¹³

The prevalence of mental illness in the elderly is further demonstrated by more specific statistical findings. Depression is the predominant risk factor for suicide in older adults. The elderly have the highest suicide rate, with older white men committing suicide six times more often than the general population.¹⁴ Approximately half the patients that have been recently relocated to nursing homes are at a heightened risk of depression.¹⁵ Up to thirty-seven percent of older primary care patients suffer from symptoms of depression.¹⁶

Under most insurance plans, benefits for mental illness are less than those provided for physical illness.¹⁷ In fact, in comparison to physical illness benefits, the Surgeon General has referred to mental health insurance benefits as “inferior.”¹⁸ This statement is supported by the limitations of a typical plan. The limitations are described in Table 1 below. As a result of this “inferior” coverage, most people in need of treatment for mental illness quickly exhaust the mental illness benefits of their insurance plans.¹⁹ Furthermore, employees as a whole are much less frequently insured for mental illness as compared to physical illness.²⁰

13. *See id.*

14. *See id.*

15. *See id.*

16. *See id.*

17. *See* Substance Abuse & Mental Health Servs. Admin., *New Study Examines Expansion of Mental Health/Substance Abuse Insurance Benefits* (visited Mar. 29, 2000) <<http://www.health.org/pressrel/mar98/6.htm>>; *see also* Christopher Aaron Jones, *Legislative “Subterfuge”?: Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*, 50 VAND. L. REV. 753, 755–56 (1998). The reasons for this will be discussed *infra*, Part III.

18. *See* *The Surgeon General’s Report*, *supra* note 1, at ch. 5.

19. *See* Maggie D. Gold, *Must Insurers Treat All Illnesses Equally?—Mental vs. Physical Illness: Congressional and Administrative Failure to End Limitations to and Exclusions from Coverage for Mental Illness in Employer-Provided Health Benefits Under the Mental Health Parity Act and the Americans with Disabilities Act*, 4 CONN. INS. L.J. 767, 770 (1997/1998).

20. *See* M. Susan Ridgely & Howard H. Goldman, *Putting the “Failure” of National Health Care Reform in Perspective: Mental Health Benefits and the “Benefit” of Incrementalism*, 40 ST. LOUIS U. L.J. 407, 415 (1996) (relating that 37% of employees were covered for inpatient treatment, and only 6% of employees for outpatient treatment).

TABLE 1**Physical vs. Mental Illness Benefits in the Typical Insurance Plan²¹**

	PHYSICAL ILLNESS	MENTAL ILLNESS
Lifetime maximum reimbursement	\$100,000 ²²	\$50,000 ²³
Annual maximum reimbursement	\$100,000 or \$250,000 ²⁴	Outpatient: \$2000 ²⁵ Total: \$10,000 ²⁶
Annual inpatient hospital day limit	Unlimited ²⁷	30 days ²⁸
Annual outpatient day limit	Unlimited ²⁹	20 days ³⁰
Coinsurance for outpatient services	20% ³¹	50% ³²

Of more interest to the elderly are the mental illness insurance provisions of Medicare.³³ Medicare covers ninety percent of all older

21. The figures in this table are the maximums insurance companies allow. In practice, under managed care, reaching these maximums is often a struggle, with continuation of treatment beyond five days or sessions requiring authorization. See B. Karon, *Provision of Psychotherapy Under Managed Mental Health Care: A Growing Crisis and a National Nightmare*, 26 PROF. PSYCHOL.: RES. & PRAC. 5, 6 (1995); W.G. Herron & L.K. Adlerstein, *The Dynamics of Managed Mental Health Care*, 75 PSYCHOL. REP. 723, 741 (1994).

22. See Jones, *supra* note 17, at 755 n.13.

23. See *id.*; see also Louis de la Parte Fla. Mental Health Inst., *CBO's Estimates of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103* (visited Mar. 29, 2000) <<http://www.fmhi.usf.edu/parity/cboestimate.html>>.

24. See 142 CONG. REC. S9899, S9919 (1996).

25. See Leslie Warstein Hann, *Unintended Consequences: New Federal Law to Expand Mental Health Benefits Could Result in Less Coverage*, BEST'S REV., Mar. 1997, at 56.

26. See Roland Sturm, *How Expensive Is Unlimited Mental Health Care Coverage Under Managed Care?*, 278 JAMA 1533 (1997).

27. See Jones, *supra* note 17.

28. See Louis de la Parte Fla. Mental Health Inst., *supra* note 21.

29. See *id.*

30. See *id.* The limitations of 30 inpatient days and 20 outpatient sessions were the minimums mandated by the HMO Act of 1973. See L.M. Richardson & C.S. Austad, *Realities of Mental Health Practice in Managed-Care Settings*, 22 PROF. PSYCHOL.: RES. & PRAC. 52, 53 (1991).

31. See Louis de la Parte Fla. Mental Health Inst., *supra* note 21.

32. See *id.*

Americans and is their major source of health insurance.³⁴ Medicare is bifurcated into Part A³⁵ and Part B.³⁶ Part A covers hospitalization and Part B covers physician fees.³⁷ In terms of mental illness benefits, Medicare provides fewer benefits than it does for physical illness:

TABLE 2
Physical vs. Mental Illness Benefits Under Medicare

	Physical Illness	Mental Illness
Part A	90 days per spell of illness, plus 60 additional lifetime reserve days ³⁸	190 inpatient hospital days lifetime limit ³⁹
Part B	80% of approved charges ⁴⁰	50% of approved charges ⁴¹

As a result of the combination of the high prevalence of mental illness in the elderly and the limited insurance benefits for treatment of mental illness in general, and specifically under Medicare, the elderly have been disproportionately denied much needed treatment.⁴²

33. See 42 U.S.C. §§ 1395, 1395ccc (1999).

34. See LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 57 (2d ed. 1999). Despite the availability of Medigap policies to fill the gaps in Medicare's benefits, none of the available policies extend the mental illness benefits of Medicare. See *id.* at 89-95.

35. See *id.* at 56.

36. See *id.*

37. See *id.*

38. See 42 U.S.C. § 1395y(a)(1). A spell of illness is the period that begins with admission to a hospital and ends with discharge. After one spell ends, a new spell restarts the per-day limitations. There are no limits on the number of spells of illness to which a beneficiary is entitled. See FROLIK & KAPLAN, *supra* note 34, at 65-67 (1999).

39. See 42 U.S.C. § 1395d(b)(3) (1999).

40. See 42 U.S.C. § 1395l(a). Approved charges are determined by Medicare and may be less than the actual charges. See FROLIK & KAPLAN, *supra* note 34, at 78-79.

41. See 42 U.S.C. §§ 1395l(a), (c). Medicare considers 62.5% of approved mental health charges as incurred expenses and then covers 80% of that amount, which results in 50% coverage of the approved charges. See 42 C.F.R. § 410.155(b) (1999).

42. See *The Surgeon General's Report*, *supra* note 1, at ch. 5.

B. Pre-MHPA Challenges to Insurance Benefits Disparity

Prior to the passage of the MHPA, plaintiffs adversely affected by disparate benefits had two avenues of remedy: the Americans with Disabilities Act (ADA)⁴³ and the “definitional approach.”⁴⁴

1. CHALLENGES UNDER THE ADA

Beneficiaries have challenged disparate insurance benefits under the ADA by claiming that the provision of lesser mental health benefits constitutes discrimination on the basis of disability.⁴⁵ However, due to the structure of the ADA, plaintiffs historically have been largely unsuccessful in such challenges. First, such suits are brought under Title III,⁴⁶ which applies to places of public accommodation. Courts of Appeals have generally held that insurance offices are not places of public accommodation, which defeats plaintiffs’ suits.⁴⁷ In *Parker v. Metropolitan Life Insurance Co.*,⁴⁸ the Sixth Circuit Court of Appeals reasoned that since the beneficiaries did not actually enter the insurance company office and that because most benefits are obtained through employers, an insurance company is not a place of public accommodation under the ADA.⁴⁹ This reasoning was also followed by the Third and Ninth circuits.⁵⁰

43. 42 U.S.C. §§ 12101–12117.

44. See Brian D. Shannon, *The Brain Gets Sick, Too—The Case for Equal Insurance Coverage for Serious Mental Illness*, 24 ST. MARY’S L.J. 365, 376 (1993). A challenge under the definitional approach involves an attempt by the plaintiff to force an interpretation of the insurance policy language which will characterize a traditionally thought of mental illness as a physical illness, in an effort to obtain the better benefits afforded to physical illness. See *id.*

45. See generally Nicole Martinson, *Inequality Between Disabilities: The Different Treatment of Mental Versus Physical Disabilities in Long-Term Benefit Plans*, 50 BAYLOR L. REV. 361 (1998) (detailing cases brought under the ADA challenging disparate benefits offered by insurers).

46. 42 U.S.C. §§ 12181–12189. For a discussion of the applicability of Title III of the ADA to insurance companies, see Luke A. Sobota, *Does Title III of the Americans with Disabilities Act Regulate Insurance?*, 66 U. CHI. L. REV. 243, 248–57 (1999).

47. See, e.g., *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006 (6th Cir. 1997). A number of lower courts have come to the opposite conclusion, that insurance offices are places of public accommodation. See *Lewis v. Aetna Life Ins. Co.*, 982 F. Supp. 1158, 1164–5 (E.D. Va. 1997); *World Ins. Co. v. Branch*, 966 F. Supp. 1203, 1207 (N.D. Ga. 1997); *Cloutier v. Prudential Ins. Co. of Am.*, 964 F. Supp. 299, 301 (N.D. Cal. 1997); *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1321–22 (C.D. Cal. 1996); *Doukas v. Metropolitan Life Ins. Co.*, 950 F. Supp. 422, 426 (D.N.H. 1996); *Baker v. Hartford Life Ins. Co.*, 1995 WL 573430, at *3 (N.D. Ill. 1995).

48. 121 F.3d 1006 (6th Cir. 1997).

49. See *id.* at 1010–12. For a comprehensive discussion of the *Parker* case, see Nancy Lee Firak, *Threshold Barriers to Title I and Title III of the Americans with Dis-*

At least one Court of Appeals has disagreed. In *Carparts Distribution Center v. Automotive Wholesaler's Ass'n of New England*,⁵¹ the First Circuit held that an insurance company is a place of public accommodation, reasoning that an opposite holding would result in inconsistency depending on the means the beneficiary used to obtain the policy.⁵² This line of reasoning was followed in *Lewis v. Aetna Life Insurance Co.*,⁵³ in which the court held that Title III prohibits discrimination by an insurer regardless of the mode of purchase of the insurance policy.⁵⁴

[Under the majority (*Parker*) approach] a place of public accommodation would be barred by Title III from discriminating in the provision of goods and services sold on its physical premises, but the same establishment would be free to discriminate in the provision of goods and services purchased by mail order or by telephone. Thus, a department store which could not refuse to sell shoes to disabled customers who visited the store's downtown business location could freely refuse services to disabled customers who ordered from the store's catalog. It is difficult to believe that Congress intended to withhold the protections of the ADA from the millions of disabled persons who buy their goods by telephone, mail-order, or home delivery without ever entering the physical premises of a business establishment. It is even more difficult to believe that Congress intended this result to apply to the insurance industry, whose goods and services (insurance policies) are routinely purchased by customers who never set foot in an insurance office, as is the case here. Indeed, under defendants' construction, an insurer could freely discriminate in the provision of insurance without fear of ADA Title III simply by not maintaining a physical office or by marketing its policies via the U.S. mail. This would directly conflict with Congress' purpose in enacting the ADA to "provide a clear and comprehensive mandate for the elimination of discrimination against individuals with disabilities."⁵⁵

abilities Act: Discrimination Against Mental Illness in Long-Term Disability Benefits, 12 J. L. & HEALTH 205, 248-308 (1997-98).

50. See *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612-14 (3d Cir. 1998) ("The plain meaning of Title III is that a public accommodation is a place, leading to the conclusion that '[i]t is all of the services which the public accommodation offers, not all services which the lessor of the public accommodation offers[,] which fall within the scope of Title III.'" (quoting *Stoutenborough v. National Football League, Inc.*, 59 F.3d 580, 583 (6th Cir. 1995) and *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115 (9th Cir. 2000)).

51. 37 F.3d 12 (1st Cir. 1994).

52. See *id.* at 19.

53. 982 F. Supp. 1158 (E.D. Va. 1997).

54. See *id.* at 1165.

55. *Id.* at 1164-65. The dissent in *Parker* expresses the same concern, stating, "It boggles the mind to think that Congress would include only the few people

Second, three Courts of Appeals and a majority of lower courts have interpreted the ADA to prohibit discrimination based on disability only in comparison to the nondisabled population, not in comparison to other disabled groups.⁵⁶ This interpretation has eliminated relief under the ADA for suits over disparate mental illness insurance coverage. In part, the basis for these holdings is concern by the courts for the well-being of the insurance industry:

So long as every employee is offered the same plan regardless of that employee's contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities. The ADA does not require equal coverage for every type of disability; such a requirement, if it existed, would destabilize the insurance industry in a manner definitely not intended by Congress when passing the ADA.⁵⁷

Two district courts, however, have disagreed and held that discrimination may occur without regard to comparison to the non-disabled.⁵⁸ Thus, in *Lewis v. Aetna Life Insurance Co.*,⁵⁹ the court stated that, "the ADA prohibits discrimination on the basis of an individual's particular disability. Therefore, whether a disabled person is treated differently than a non-disabled person or another disabled person, the same wrong has occurred. That is, the person has been discriminated against because of his particular disability."⁶⁰ In *Boots v. Northwestern Mutual Life Insurance Co.*,⁶¹ the court relied on the Supreme Court's rejection in *Olmstead v. L.C.*⁶² of the "argument that disparate treatment of different members of a protected class is not discrimination," and

who walk into an insurance office to buy health insurance but not the millions who get such insurance at work. This distinction drawn by the Court produces an absurd result." *Parker*, 121 F.3d at 1021.

56. See *Parker*, 121 F.3d at 1015 ("[T]he ADA does not mandate equality between individuals with different disabilities. Rather, the ADA prohibits discrimination between the disabled and the non-disabled"); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608 (3d Cir. 1998); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1117 (9th Cir. 2000); see also *Equal Employment Opportunity Comm'n v. Bath Iron Works Corp.*, 1999 U.S. Dist. LEXIS 10600, at *13-16 (D. Me. 1999); *Conners v. Maine Med. Ctr.*, 42 F. Supp. 2d 34, 55 (D. Me. 1999); *Cloutier v. Prudential Ins. Co. of Am.*, 964 F. Supp. 299, 301 (N.D. Cal. 1996); *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1321-22 (C.D. Cal. 1996); *Doukas v. Metropolitan Life Ins. Co.*, 950 F. Supp. 422, 426 (D.N.H. 1996); *Baker v. Hartford Life Ins. Co.*, 1995 WL 573430, at *3 (N.D. Ill. 1995).

57. *Ford*, 145 F.3d at 608.

58. See *Lewis*, 982 F. Supp. at 1168-69; *Boots v. Northwestern Mut. Life Ins. Co.*, 1999 U.S. Dist. LEXIS 20974, at *22-23 (D.N.H. 1999).

59. 982 F. Supp. 1158.

60. *Id.* at 1168.

61. 1999 U.S. Dist. LEXIS 20974.

62. 119 S. Ct. 2176, 2186 (1999).

concluded that the ADA is violated by insurance policies which distinguish between mental and physical disabilities.⁶³

Legislative history has also been on the side of the majority interpretation of the ADA. The Senate Labor and Human Resources Committee report stated that:

[E]mployers may not deny health insurance coverage completely to an individual based on the person's diagnosis or disability. For example, . . . it is permissible for an employer to offer insurance policies that limit coverage for certain procedures or treatments, e.g., only a specified amount per year for mental health coverage. . . .⁶⁴

Until recently, this interpretation of the ADA received support from the Equal Employment Opportunity Commission (EEOC), the federal agency charged with eradicating discrimination.⁶⁵ The EEOC has issued guidance, which although never published in the Federal Register or adopted as regulations, may be considered by courts.⁶⁶ This guidance states that disparity between physical and mental illness benefits in insurance policies is not discrimination.⁶⁷ The EEOC, however, recently changed its interpretation of the Act, finding that the Act does not allow differential insurance coverage practices.⁶⁸ This

63. See *Boots*, 1999 U.S. Dist. LEXIS 20974, at *22.

64. S. REP. NO. 101-116, at 29 (1989).

65. See EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, INTERIM ENFORCEMENT GUIDELINES ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE, reprinted in *THE LAW OF DISABILITY HANDBOOK: STATUTES AND REGULATORY GUIDANCE* 141 (Ruth Colker et al. eds., 2d ed. 1999). See generally Gold, *supra* note 19, at 795-804 (discussing the EEOC guidance).

66. See Gold, *supra* note 19, at 795.

67. See INTERIM ENFORCEMENT GUIDELINES ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE, *supra* note 65, at 143:

[A] feature of some employer provided health insurance plans is a distinction between the benefits provided for the treatment of physical conditions on the one hand, and the benefits provided for the treatment of "mental/nervous" conditions on the other. Typically, a lower level of benefits is provided for the treatment of mental/nervous conditions than is provided for the treatment of physical conditions. . . . Such broad distinctions, which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA.

68. See Interim Rules for Mental Health Parity, 62 Fed. Reg. 66,932, 66, 934 n.3 (1997) ("[T]he Americans with Disabilities Act (ADA) prohibits disability based

new interpretation has been called into question and was not given deference by one court, who claimed the guidance conflicts with the plain language of the Act, binding Title III regulations, and other EEOC guidance.⁶⁹ Additionally, the court stated that the EEOC does not have administrative authority over Title III.⁷⁰

Lastly, seven Courts of Appeals have explicitly held that a limitation on mental health benefits in a long-term disability plan does not violate the ADA.⁷¹

Thus, relief under the ADA prior to the passage of the MHPA was in theory an option, but in practice was difficult to obtain for the beneficiary.

2. THE DEFINITIONAL APPROACH

A more successful, but more limited, strategy has been to attack the language of the insurance contract itself. One approach is to argue that the mental illness is actually a physical illness with behavioral symptoms. Thus, in *Arkansas Blue Cross & Blue Shield v. Doe*,⁷² the beneficiary was able to obtain benefits for treatment of bipolar disorder by arguing the illness to be physical in nature, and thus was entitled to the greater physical illness benefits of the insurance policy.⁷³ In so holding, the court gave great weight to the testimony of one of the beneficiary's experts and found that many mental illnesses "manifest some behavioral or emotional disturbances, but the causes of those manifestations are physical and biological in nature as distinguished from mental."⁷⁴

A second approach is to challenge the language as ambiguous, and thus invoke the canon of *contra proferentem*. For example, the

distinctions (including such distinctions relating to the provision of mental health benefits) in employer provided health insurance plans . . .").

69. See *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1117 (9th Cir. 2000).

70. See *id.*

71. See *EEOC v. Staten Island Savings Bank*, 2000 U.S. App. LEXIS 4633, at *1, *12 (2d Cir. 2000); *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1116-18 (9th Cir. 2000); *Kimber v. Thiokol Corp.*, 196 F.3d 1092, 1101-02 (10th Cir. 1999); *Lewis v. Kmart Corp.*, 180 F.3d 166, 170 (4th Cir. 1999), *cert. denied*, 120 S. Ct. 978 (2000); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 608-10 (3d Cir. 1998), *cert. denied*, 525 U.S. 1093 (1999); *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1015-19 (6th Cir. 1997) (en banc), *cert. denied*, 522 U.S. 1084 (1998); *EEOC v. CNA Ins. Cos.*, 96 F.3d 1039, 1044-45 (7th Cir. 1996).

72. 733 S.W.2d 429 (Ark. Ct. App. 1987).

73. See *id.* at 432.

74. *Id.* at 431.

plaintiff in *Kunin v. Benefit Trust Life Insurance Co.*,⁷⁵ used this approach, and the court held the term “mental illness” to be ambiguous and construed the ambiguity against the insurance company.⁷⁶ In doing so, the court pointed to the lack of a definition or explanation of mental illness, lack of illustrations or examples of inclusions or exclusions, and lack of indication of whether etiology or manifestation was the determining factor.⁷⁷

A third approach is to shift the focus of the meaning of the insurance policy language from etiology to symptomatology or vice versa. Thus, a beneficiary will attempt to argue that the language refers to the etiology if the etiology is biological (as in the case of bipolar disorder), or that the language refers to the symptomatology if that is physical in nature (as in the case of anorexia).⁷⁸ This strategy allowed the plaintiff in *Simons v. Blue Cross & Blue Shield*⁷⁹ to prevail by arguing the treatment of anorexia nervosa was directed at the attendant physical ailment as opposed to the underlying psychiatric etiology.⁸⁰ The reverse approach, however, failed in *Equitable Life Assurance Society v. Berry*,⁸¹ in which the plaintiff, suffering from manic depression, argued for coverage on the basis of the illness being biological in nature.⁸²

C. The Case for Parity

The prevalence and seriousness of mental illness, combined with the difficulty of insurance beneficiaries to obtain mental illness benefits that are equal, or at least comparable, to physical illness benefits,

75. 910 F.2d 534 (9th Cir. 1989).

76. *See id.* at 538–39.

77. *See id.* at 541.

78. For example, assume the insurance language excludes coverage for treatment of mental illness. A beneficiary suffering from bipolar disorder (a biological based disorder with behavioral symptomatology) will focus on the etiology as being biological and argue that the policy should cover treatment. A beneficiary suffering from anorexia (a psychological based disorder with physical symptomatology) will focus on the symptoms as being biological and argue that the policy should cover the treatment.

79. 536 N.Y.S.2d 431 (N.Y. App. Div. 1989).

80. *See id.* at 435.

81. 260 Cal. Rptr. 819 (Cal. Ct. App. 1989).

82. *See id.* at 824. The court held that “[e]very reasonable layman would view a person manifesting such derangement as suffering from a mental disease.” *Id.* In so holding, the court explicitly gave more deference to the layman’s perspective of the term mental illness, than to the medical profession’s determination of what constitutes a mental versus a physical illness. *See id.* at 824, n.2.

has resulted in an ongoing legislative movement to federally mandate insurance benefits parity.⁸³ While there are a number of arguments against parity, there are many more arguments for parity in insurance benefits.⁸⁴

The arguments against insurance benefits parity mostly revolve around increased cost, which, largely promulgated by the insurance industry, overlap with the reasons why disparity exists in the first place.⁸⁵ First, there is a concern over cost containment.⁸⁶ Insurance companies view mental health benefits as one of the fastest growing areas in health care financing.⁸⁷ By limiting the benefits for mental illness, insurance companies claim they can keep costs down and thereby maintain current levels of coverage for other illnesses and allow a greater level of access to more people.⁸⁸

Second, insurance companies justify limited mental illness benefits on the ground of moral hazard.⁸⁹ “Moral hazard” refers to the hypothesized risk of an increased demand for services once an insurer decides to cover those services.⁹⁰ The underlying concern of this argument is the nebulous nature of mental illness and the attendant difficulty in distinguishing true illness from life’s day-to-day stress.⁹¹ Further, insurers justify coverage limitations on these grounds by arguing that there is no justification for covering treatment which a beneficiary would not have sought out if he or she had to cover the cost out of pocket.⁹²

83. See *The Surgeon General’s Report*, *supra* note 1, at ch. 6. <<http://www.surgeongeneral.gov/library/mentalhealth/chapter6>>. On the federal level, legislation has been introduced since the 1970s. See *id.* State legislative efforts have also been ongoing. See *id.*

84. See generally Gold, *supra* note 19, at 773–79; Jones, *supra* note 17, at 758–64; Shannon, *supra* note 44.

85. See generally Gold, *supra* note 19, at 773–79; Jones, *supra* note 17, at 758–61; Shannon, *supra* note 44, at 373.

86. See Gold, *supra* note 19, at 773.

87. See Shannon, *supra* note 44, at 373.

88. See Gold, *supra* note 19, at 773; Jones, *supra* note 17, at 759.

89. See Gold, *supra* note 19, at 773–75; Jones, *supra* note 17, at 759–60.

90. See Gold, *supra* note 19, at 773–75; Jones, *supra* note 17, at 759–60.

91. See Gold, *supra* note 19, at 773–75; Jones, *supra* note 17, at 759–60.

92. See Gold, *supra* note 19, at 773–75; Jones, *supra* note 17, at 759–60. This argument is based on findings that the demand for mental health services correlates to the availability of insurance coverage for those services, as well as the lower effectiveness of mental health treatment. In regard to physical illness, moral hazard is less of a concern because of the greater certainty of physical diagnosis and treatment, as well as the belief in the necessity of the particular treatment. See *id.*

The third argument is adverse selection.⁹³ Insurers and employers are wary of increasing benefits which will attract a large number of high risk beneficiaries, and therefore adversely affect selection of these plans by employers, as well as increase the costs of premiums.⁹⁴

The argument for parity is more expansive, more substantive, and has a greater number of proponents.⁹⁵ First, disparate mental illness benefits are a product of stigma, discrimination, bias, and antiquated ideas about mental illness.⁹⁶ Mental illness has long been misunderstood and looked down upon.⁹⁷ For example, until recently, the public viewed mental illness as a curse or an affliction that one brought upon him or herself.⁹⁸ The result has been a historic disregard for treatment coverage by insurance companies.⁹⁹

Second, research has shown that serious mental illness has a biological basis.¹⁰⁰ Therefore, there is no biological justification for treating these serious mental illnesses differently from physical illness in terms of insurance coverage.¹⁰¹ Additionally, many mental illnesses are highly treatable, with success rates equal to or even higher than treatments of routinely covered physical illnesses.¹⁰²

Third, untreated mental illness has resulted in huge indirect costs to the healthcare system.¹⁰³ Indirect costs refer to lost productivity at work, school, and home due to disability.¹⁰⁴ For example, the estimated direct and indirect costs of depression are \$43 billion, not

93. See Gold, *supra* note 19, at 775; Jones, *supra* note 17, at 760.

94. See Gold, *supra* note 19, at 775. This concern over rising costs has led insurers to forgo standard underwriting practices and instead offer limited benefits. See Jones, *supra* note 17, at 785–86.

95. See Gold, *supra* note 19, at 776 n.32 (listing the numerous organizations and professional associations which support parity).

96. See Gold, *supra* note 19, at 775–76; Jones, *supra* note 17, at 761–62.

97. See Shannon, *supra* note 44, at 371.

98. See *id.*

99. See Gold, *supra* note 19, at 775–76; Jones, *supra* note 17, at 761–62.

100. See Jones, *supra* note 17, at 762 n.42. Courts have also recognized this fact. See, e.g., *Arkansas Blue Cross & Blue Shield v. Doe*, 733 S.W.2d 429, 431–32 (Ark. Ct. App. 1987); *Equitable Life Assurance Soc’y v. Berry*, 260 Cal. Rptr. 819, 824 (Cal. Ct. App. 1989).

101. See Jones, *supra* note 17, at 762.

102. See Firak, *supra* note 49, at 239; see also Jones, *supra* note 17, at 762 n.42 (“Treatment for schizophrenia has a 60 percent success rate; manic depression, 80 percent; major depression, 65 percent. Yet commonly reimbursed procedures such as angioplasty and arthrectomy have only a 41 percent and a 52 percent ratio. . . .” (quoting Sen. Pete Domenici, 142 Cong. Rec. S3591 (1996))).

103. See *The Surgeon General’s Report*, *supra* note 1 (stating that the estimate of indirect costs for 1990 was \$78.6 billion).

104. See *id.*

including suffering and diminished quality of life.¹⁰⁵ For the elderly, many of the indirect costs result from the interaction of depression with other illnesses, which leads to more doctor and emergency room visits, more medication, higher charges, and longer hospital stays.¹⁰⁶ The enactment of parity legislation would lead to an overall reduction in healthcare costs.¹⁰⁷

Fourth, many states already have implemented parity statutes, the existence of which indicates that parity in insurance coverage is a realistic goal.¹⁰⁸ As of 1999, twenty-eight states enacted parity laws, representing half the population of the country.¹⁰⁹

Therefore, while the concerns of the insurance industry may be legitimate, they are outweighed by the benefits, need for, and desirability of insurance benefits parity. All of these factors led to the enactment of the Mental Health Parity Act.¹¹⁰

D. The Mental Health Parity Act

In light of the problem of disparate health benefits under insurance plans, Congress passed the Mental Health Parity Act in 1996.¹¹¹ The Act as passed, however, represents a significant diminishment in the scope of the originally proposed bill.¹¹² The road to the passage of the Act was a long one—the first parity bill was introduced into Congress in 1992.¹¹³ While the initially proposed bill provided for com-

105. See *id.*, at ch. 5.

106. See *id.*

107. See Jones, *supra* note 17, at 763; see also Shira J. Boss, *Covering Mental Health May Be a Sane Solution*, CRAIN'S N.Y. BUS., Mar. 20, 2000, at 39 ("increasing mental health coverage may actually save companies a bundle because employees who get proper treatment miss fewer days at work, are more productive and are less likely to take leaves or go on disability.") *Id.*

108. See National Alliance for the Mentally Ill, *Parity in Insurance Coverage*, NAMI Position, *State Legislative Efforts* (visited Mar. 29, 2000) <http://www.nami.org/update/united_parity.html>. See generally Bruce Lubotsky Levin, et al., *Mental Health Parity: 1998 National and State Perspectives*, (visited Mar. 29, 2000) <<http://www.fmhi.usf.edu/institute/pubs/pdf/parity/parity98.pdf>>.

109. See National Alliance for the Mentally Ill, *supra* note 108.

110. 42 U.S.C. § 300gg-5 (1999 & Supp. 2000).

111. See Gold, *supra* note 31, at 779–82; Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63 (1997) (relating the legislative history of the MHPA).

112. See Gold, *supra* note 19, at 779–82; Shannon, *supra* note 44.

113. See Jones, *supra* note 17, at 757 n.19. "Sen. Pete Domenici, the sponsor of the MHPA, introduced the 'Equitable Health Care for Severe Mental Illnesses Act of 1992' which never became law." See *id.* (quoting S. 2696, 102d Cong. (1992), 138 CONG. REC. S6490 (1992)).

plete parity between mental and physical benefits,¹¹⁴ the bill as enacted is far less comprehensive.¹¹⁵

The MHPA's sole requirement is that insurers make annual and lifetime dollar limits of mental benefits equal to that of physical benefits.¹¹⁶ Despite this already limited concept of parity, the Act also con-

114. See Gold, *supra* note 19, at 779–81.

115. See *infra* notes 116–22 and accompanying text. See generally Health Care Fin. Admin., *Mental Health Parity*, (visited Mar. 29, 2000) <<http://www.hcfa.gov/hipaa/medicaid/hipaa/topics/mhpa.asp>>.

116. See 42 U.S.C. § 300gg-5(a)(1), (2) (1999 & Supp. 2000):

(a) In general.

(1) Aggregate lifetime limits. In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

(A) No lifetime limit. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

(B) Lifetime limit. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable lifetime limit”), the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

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

....

(2) Annual limits. In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

(A) No annual limit. If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

(B) Annual limit. If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the “applicable annual limit”), the plan or coverage shall either—

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

tains numerous exceptions. It only applies to group health plans,¹¹⁷ does not actually require an insurer to offer mental health benefits,¹¹⁸ does not affect the nature and scope of the mental health benefits offered,¹¹⁹ does not apply to small employers,¹²⁰ does not apply to Medicare, does not apply if compliance would increase the cost of the plan by more than one percent,¹²¹ and does not apply to long term disability plans. Most importantly, the Act expires September 30, 2001.¹²²

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

117. *See id.* §§ 300gg-5(a)(1), (2).

118. *See id.* § 300gg-5(b)(1):

(b) Construction. Nothing in this section shall be construed—

(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

119. *See id.* § 300gg-5(b)(2):

(b) Construction. Nothing in this section shall be construed—

....
 (2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

120. *See id.* § 300gg-5(c)(1):

(1) Small employer exemption. This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

A small employer is defined as “an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.” Interim Rules for Mental Health Parity, 62 Fed. Reg. 66932, 66934 (1997).

121. *See* 42 U.S.C. § 300gg-5(c)(2):

(2) Increased cost exemption. This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

122. *See id.* § 300gg-5(f):

(f) Sunset. This section shall not apply to benefits for services furnished on or after September 30, 2001.

III. The Shortcomings and the Detrimental Effects of the Mental Health Parity Act

As a result of the numerous exceptions to the MHPA, one commentator has stated that, "the Mental Health Parity Act is likely to do little or nothing to resolve the issue of parity among physical and mental health benefits."¹²³ Additionally, the Act, through its limitations, has the practical effect of endorsing discriminatory coverage, particularly against the elderly, and defeats attempts to challenge coverage decisions under the ADA.

A. Shortcomings of the Act

Given the numerous exceptions and limitations of the MHPA, its effect in practice is hardly noticeable. It operates to require only group health plans of large employers to equalize mental and physical benefits capitations, both lifetime and annual, if such action would increase costs by less than one percent, until September of 2001. This limited requirement allows all other insurers to avoid compliance altogether and, given the paltry cost exception,¹²⁴ may exclude most of those insurers who would otherwise be subject to the Act's provisions.

First, the exclusion of small employers from compliance with the provisions of the Act eliminates ninety-seven percent of employers from the mandates of the Act.¹²⁵ Furthermore, employees of small employers make up half of all U.S. workers, meaning that approximately eighty million employees and dependants will not benefit from the Act.¹²⁶ These exclusions greatly limit the coverage of the Act.

Second, the Act does not apply to Medicare, a federal program in which ninety percent of the elderly population is enrolled.¹²⁷ Accordingly, the MHPA effectively offers no benefit or protection to the elderly. This is a particularly questionable result of the Act. The purported impetus of the MHPA is to increase parity in insurance coverage. Yet, the one insurance scheme that government can directly change, Medicare, provides insurance benefits for mental illness that

123. Bonnie Poitras Tucker, *Symposium: Individual Rights and Reasonable Accommodation Under the Americans with Disabilities Act—Insurance and the ADA*, 46 DEPAUL L. REV. 915, 929 (1997).

124. See *supra* note 121 and accompanying text.

125. See Gold, *supra* note 19, at 784.

126. See *id.*

127. See FROLIK & KAPLAN, *supra* note 34, at 57.

are almost as poor as those of the private insurance companies to which the Act does not apply.¹²⁸ Thus, the Act intentionally excludes the vast majority of the elderly from the mandate of parity. In light of the large numbers of the elder population suffering from mental illness,¹²⁹ such a legislative exclusion is particularly harsh.

Third, the one percent cost increase exemption may further diminish the applicability of the Act.¹³⁰ The Congressional Budget Office estimated that there would be an aggregate 0.4% increase in plan expenditures due to the MHPA.¹³¹ It has been further estimated that ten percent of plans would have cost increases above one percent and thereby be untouched by the provisions of the Act.¹³² However, to date, no conclusive studies have been done to determine what the actual cost increase has been. Therefore, it is uncertain what the average cost increase will be, and hence how many plans will be exempt from the provisions of the Act.

Fourth, employers and insurers can legally respond to the mandates of the MHPA in a way detrimental to those seeking mental health treatment. One response is to cover only a percentage of mental health care costs, which is known as cost sharing and is allowed under the MHPA.¹³³ Another is to implement high coinsurance rates, and low dollar and day limits as a means of discouraging treatment.¹³⁴ Either operates to manipulate coverage in a way that complies with the MHPA while maintaining costs at current levels.¹³⁵

128. See *supra* notes 38–41 and accompanying text.

129. See *supra* notes 2–16 and accompanying text.

130. For an explanation of how the 1% increase is calculated, see Parity in the Application of Certain Limits to Mental Health Benefits, 45 C.F.R. § 146.136(f) (2000) (setting forth the procedure for determination); Jack A. Rovner, *Federal Regulation Comes to Private Health Care Financing: The Group Health Insurance Provisions of the Health Insurance Portability and Accountability Act of 1996*, 7 ANN. HEALTH L., 183, 205–06 (1998) (explaining how the procedure works).

131. See Interim Rules for Mental Health Parity, 62 Fed. Reg. 66,932, 66,940 (1997).

132. See *id.* at 66,943.

133. See Gold, *supra* note 19, at 783.

134. See *id.*

135. See *id.*; see also Hann, *supra* note 25 (“loopholes in the federal Mental Health Parity Act of 1996 permit employers to offer less coverage for mental disorders and still comply with the law”); Boss, *supra* note 107 (“when the federal Mental Health Parity Act went into effect . . . employers promptly figured out how to get around the law by limiting the number of visits for mental health treatment, rather than dollars.”).

Lastly, the requirement of parity is all but meaningless in the realm of managed care.¹³⁶ Managed care plans control access to services primarily on the basis of limitations of days of service, not dollar limits.¹³⁷ The limitations are typically thirty inpatient days and twenty outpatient sessions.¹³⁸ The maximum reimbursement a beneficiary can obtain, both per year and over a lifetime, does not come close to the typical physical illness dollar limit of the plan. For example, twenty outpatient sessions, costing \$100 per session,¹³⁹ reimbursed at fifty percent,¹⁴⁰ equates to \$1000 per year. Thirty inpatient days, costing \$500 per day,¹⁴¹ reimbursed at eighty percent,¹⁴² equates to \$12,000 per year. Thus, though the new annual limit under the MHPA for mental illness benefits would be \$100,000 or \$250,000,¹⁴³ the beneficiary would still only be eligible for \$13,000 per year in coverage.¹⁴⁴ Therefore, the MHPA would do absolutely nothing to increase parity or affect coverage at all. Given the fact that approximately seventy percent of Americans with health insurance are covered by managed behavioral health programs, the result is 125 million Americans who receive no benefit under the MHPA.¹⁴⁵

B. Endorsement of Discriminatory Coverage

Outside of the ADA,¹⁴⁶ the Mental Health Parity Act is the only piece of legislation which addresses insurance benefits disparity. Therefore, an insurer's sole duty in this area is to comply with the

136. See Jones, *supra* note 17, at 770.

137. See *id.*

138. See *supra* notes 26, 28 and accompanying text.

139. See Sandy Rovner, *Shrinkage of Mental Health Benefits*, WASHINGTON POST, Mar. 3, 1992, at Z9.

140. See *supra* note 29.

141. See Rovner, *supra* note 139.

142. See Hann, *supra* note 25.

143. See *supra* note 22 and accompanying text.

144. The lifetime limit would be more meaningful. In the event that a beneficiary were to use these maximum allowed benefits over the course of a lifetime (say, every year for 50 years), the total cost would be \$650,000, which is nevertheless still far short of the \$1,000,000 limit placed on physical illness. The ability of a patient to logistically achieve this maximum benefit is questionable though, because psychiatric treatment is usually ongoing in nature. In other words, the beneficiary would likely exhaust his or her annual session and inpatient limitations over the course of a month or two, and then have to wait until the next year to have treatment covered. Thus, it is the annual limit that is more significant.

145. See Hann, *supra* note 25.

146. The application of the ADA to insurance benefits parity is now precluded. See *infra* notes 154–66 and accompanying text.

Act's provisions. In other words, an insurer will suffer no liability as long as it meets the requirements of the Act.¹⁴⁷

Given the minuscule impact of the Act, there is very little chance of an insurer being held liable for disparate benefits. The fact is that, by enacting such limited legislation, Congress has in effect endorsed discriminatory benefits provisions by insurers. Outside of large employer group health plans, no insurers need provide even the semblance of parity in health benefits. In addition, large employer group health plans only need effect parity in capitations, a duty from which they may escape due to the cost exception.¹⁴⁸

Therefore, by enacting this legislation, Congress has effectively legalized discriminatory insurance coverage. Prior to the enactment of the MHPA, there was at least some uncertainty as to whether providing disparate insurance benefits was actionable. Now, by so severely limiting parity of requirements, Congress has essentially endorsed discrimination against the mentally ill. In the case of the elderly, the result is even worse: due to the practical exclusion of the elderly from the benefits the Act requires,¹⁴⁹ Congress has endorsed indirect age discrimination. That is to say, by enacting legislation which benefits the mentally ill, but which excludes legislation that benefits the majority of the elderly, Congress has acted in a discriminatory manner. This action, however, does not constitute legally actionable discrimination, because Congress has sought to prohibit age discrimination only in the context of employment.¹⁵⁰ Thus, despite its

147. The only statute addressing insurance benefits parity, besides possibly the ADA, is the MHPA. See *Equal Employment Opportunity Comm'n v. CNA Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir. 1996).

148. See *supra* note 121.

149. See *supra* note 121 and accompanying text.

150. See 29 U.S.C. §§ 621–634 (1999). The Age Discrimination in Employment Act prohibits discrimination in hiring, employment, and discharge on the basis of age. See JOHN E. NOWAK & RONALD D. ROTUNDA, *CONSTITUTIONAL LAW* 904–05 (4th ed. 1991). Furthermore, classifications based on age are not considered suspect, and thus are only evaluated via the rational basis test. See *id.* But, given the nature of the MHPA in light of its inapplicability to Medicare, Justice White's instruction in *Vance v. Bradley*, 440 U.S. 93 (1979), regarding statutes which do not implicate suspect classes, is potentially relevant: "we will not overturn such a statute unless the varying treatment of different groups or persons is so unrelated to the achievement of any combination of legitimate purposes that we can only conclude that the legislature's actions were irrational." *Id.* at 97. The MHPA, given its exclusion of the elderly, might be such a statute.

good-natured intent,¹⁵¹ Congress has effectively legalized discrimination in the field of insurance benefits.

C. Preclusion of the ADA

Perhaps the most detrimental and unexpected effect of the enactment of the Mental Health Parity Act is its preclusion of the ADA as a vehicle for remedy for disparate benefits.

Prior to the passage of the MHPA, beneficiaries attempted to seek relief from disparate benefits by bringing suit under the ADA.¹⁵² Given the general thrust of the ADA, the prohibition against discrimination on the basis of disability,¹⁵³ such a suit appeared to be a reasonable means of effecting parity in insurance benefits. An insurer who offers diminished benefits on the basis of disability logically appears to be discriminating on the basis of disability. However, such suits usually failed due to insurance offices not qualifying as places of public accommodation,¹⁵⁴ or alternatively because courts have held the ADA only to guard against discrimination based on disability in relation to the nondisabled.¹⁵⁵ Thus, disparate benefits are not discriminatory, since the disabled group (the mentally ill) is only being discriminated against in reference to another disabled group (the physically ill). Yet despite these problems, the opportunity to seek relief did exist under the ADA.

Following the passage of the MHPA, however, courts have interpreted the MHPA as an act that renders the ADA inapplicable to matters of insurance coverage inequity. Thus, in *Parker v. Metropolitan Life Insurance Co.*, the court held that:

Congress' passage of the Mental Health Parity Act suggests Congress believed that the ADA neither governs the content of insurance policies nor requires parity between physical and mental illnesses; thus, passage of a law requiring such parity was required

151. Though mindful of the limitations of the MHPA, the Act's sponsor, Senator Pete Domenici, has characterized the passage of the Act as a commendable action of Congress, stemming from concern for insurance benefits disparity. See Shannon, *supra* note 111, at 14, 104 n.181 ("Congress is sending 'a little ray of hope to the millions of American People.'")

152. See *supra* notes 45-70 and accompanying text.

153. See 42 U.S.C. §§ 12101-12117 (1999).

154. See *supra* notes 43-54 and accompanying text.

155. See *supra* notes 56-63 and accompanying text.

if Congress desired insurance carriers to cease including disparate mental and physical health benefits in insurance policies.¹⁵⁶

Or as another court put it, “such congressional action reveals both that the ADA does not contain parity requirements and that no parity requirements for mental and physical disability benefits have been enacted subsequent to the ADA.”¹⁵⁷ Courts also have pointed to the Act’s legislative history. Prior to the passage of the MHPA, there existed some debate over the ADA’s application to disparate health insurance benefits. In light of the congressional hearings surrounding the passage of the MHPA, however,

[f]ew, if any, mental health advocates have thought that the result they would like to see has been there all along in the ADA. This is well-illustrated by the debate over a proposed amendment to the Health Insurance Portability and Accountability Act of 1996. The amendment, which was defeated before final passage of the bill, would have required parity of coverage for mental and physical conditions. This debate reinforces our conclusion based on the language of the ADA that the issue of parity among physical and mental health benefits is one that is still in the legislative arena.¹⁵⁸

Therefore, the basic reasoning is that Congress would not have enacted the MHPA to effect parity if the ADA already mandated such parity. In other words, if the ADA mandated parity the MHPA would be redundant legislation.¹⁵⁹

In the arena of long term disability insurance the picture is potentially even bleaker. Expanding upon the reasoning that the MHPA precludes application of the ADA to benefits disparity, one court held that the failure of the MHPA to apply to long term disability insurance, combined with the inapplicability of the ADA, necessarily means that there is no legislation that mandates parity between bene-

156. 121 F.3d 1006, 1018 (6th Cir. 1997); *see also* *Brewster v. Cooley Associates/Counseling*, 1997 WL 823634, at *1 (D.N.M. 1997).

157. *See Ford v. Schering-Plough Corp.*, 145 F.3d 601, 610 (3d Cir. 1998).

158. *Equal Employment Opportunity Comm’n v. CNA Ins. Cos.*, 96 F.3d 1039, 1044 (7th Cir. 1996).

159. *See Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1117 (9th Cir. 2000); *see also CNA Insurance Cos.*, 96 F.3d at 1044. *See generally* *Connors v. Maine Med. Ctr.*, 42 F. Supp. 2d 34, 45–50 (D. Me. 1999) (discussing these cases). One court that held that the ADA does not cover insurance declined to follow this reasoning: “We decline, however, to place as much weight on this subsequent legislative history as do some of our sister circuits for two reasons. First, ‘subsequent legislative history is generally a ‘hazardous basis for inferring the intent of an earlier’ Congress.’ . . . Second, the MHPA and the other proposed bills address themselves chiefly to non-disability based distinctions.” *EEOC v. Staten Island Savings Bank*, 2000 U.S. App. LEXIS 4633, at *1, *26–27 (2d Cir. 2000).

fits in long term disability insurance.¹⁶⁰ Thus, in *Major Rogers v. Department of Health and Environmental Control*, the court held that, “while Congress likely realized that equality between the two types of disabilities was not covered by the ADA, it sought to remedy the absence only in the context of health insurance coverage, not long-term disability policies.”¹⁶¹ However, in *Boots v. Northwestern Mutual Life Insurance Co.*, the court distinguished the MHPA from the ADA on the basis of medical illness and disability being two separate concepts, and held that the passage of the MHPA did not necessarily mean that the ADA does not mandate parity in insurance benefits.¹⁶² In no uncertain terms, the court asserted:

The Mental Health Parity Act requires group health benefit plans that provide medical, surgical, and mental health benefits to provide coverage for psychological treatment equal to that provided for physical care. . . . What the ADA prohibits is discriminating against an individual based on disability. Just as most employees who use their health insurance to cover medical costs are not physically disabled, most employees seeking insurance coverage for mental health treatment are not mentally disabled. Thus the 1996 Act does not cover the same ground at all.¹⁶³

In light of the courts’ treatment of the ADA in relation to the MHPA, the remedial landscape is quite disheartening to beneficiaries and supporters of insurance benefits parity. A beneficiary suffering from mental illness who is subject to disparate benefits has virtually no recourse. Despite the very reasonable argument that providing disparate benefits equates to discrimination on the basis of disability, the beneficiary is foreclosed from a challenge under the ADA due to the passage of the MHPA. If the insurer to be challenged is not a large employer group health plan, then the beneficiary cannot even seek relief under the MHPA. Even if the insurer is a large employer group health plan, recovery may be foreclosed due to the cost exception.¹⁶⁴

Thus, the MHPA does little to increase parity. To the contrary, it outright reduces it, ignores the elderly, endorses discrimination, and eliminates any remedy to disparate health benefits.

160. See *Major Rogers v. Department of Health & Env'tl. Control*, 985 F. Supp. 635, 639 (D.S.C. 1997).

161. *Id.*

162. See *Boots v. Northwestern Mutual Life Ins. Co.*, 1999 U.S. Dist. LEXIS 20974, at *28 (D.N.H. 1999).

163. *Id.*

164. See *supra* note 121 and accompanying text.

IV. Recommendation: How to Establish Real Parity

Though the passage of the Mental Health Parity Act may have been fraught with good intentions, the Act itself does little to effect these intentions.¹⁶⁵ As demonstrated, the ultimate result of the Act is to decrease parity between physical and mental health treatment benefits, thus furthering the discrimination against the mentally ill that the Act was passed to remedy. Such a questionable result raises the question of what can be done to reverse, or at least decrease, the Act's detrimental affect on health benefits parity.

From a judicial standpoint, the only possible solution lies with the ADA. The text of the MHPA is explicitly clear, thus eliminating any sort of interpretation challenge. Therefore, given the lower courts' holdings that the passage of the MHPA eliminates remedy under the ADA, the only available judicial solution would be for the Supreme Court to hear such a case and decide that the MHPA does not preclude remedy under the ADA. This, of course, is dependent on the highly speculative occurrence of such a challenge being instituted, being heard by the Court, and resulting in a reversal of lower courts' holdings.

From a legislative standpoint, there are a number of solutions to the problems of the MHPA. The first would be to enact legislation that mandates parity not just in terms of annual and lifetime limits, but in terms of actual access to services. The requirement of parity in annual and lifetime limits does little, if anything, to effect even the weakest notion of parity.¹⁶⁶ There are generally no restrictions on access to physical treatment services, while most insurers place very severe restrictions on access to mental health treatment services.¹⁶⁷ Thus, enactment of legislation that requires parity in access would eliminate the beneficiaries' current inability to obtain mental health coverage equal to that of physical coverage.

Progress towards this solution was made with the introduction of one bill in the House of Representatives and one in the Senate. Representatives Roukema,¹⁶⁸ DeFazio,¹⁶⁹ and Wise¹⁷⁰ introduced The

165. Or perhaps the impetus was guilt. See Jones, *supra* note 17, at 771 ("the MHPA may serve as a salve for the conscience of legislators who can now feel that they have done their part in the fight for equal insurance benefits for those with mental illness.") *Id.*

166. See *supra* notes 123-45 and accompanying text.

167. See *supra* notes 20-30 and accompanying text.

168. Republican-New Jersey.

Mental Health and Substance Abuse Parity Amendments of 1999 into the House in April of 1999.¹⁷¹ The Bill would provide full parity for insurance coverage of mental health and addiction services.¹⁷² Like the MHPA, however, the bill excludes Medicare from its coverage.¹⁷³ The second session of the 106th Congress adjourned with the bill still in committee.¹⁷⁴

Additionally, Senators Domenici¹⁷⁵ and Wellstone¹⁷⁶ introduced the Mental Health Equitable Treatment Act of 1999 into the Senate in April of 1999.¹⁷⁷ The Senate bill prohibits group health plans from setting arbitrary day and visit limits on services for all mental disorders, and generally provides full parity, but only for specific severe biological based mental diseases, which leaves out many other debilitating mental illnesses such as personality disorders.¹⁷⁸ The bill also eliminates the sunset provision¹⁷⁹ of the MHPA, and lowers the small business exemption to firms with less than twenty-five employees.¹⁸⁰ Again, however, the bill does not apply to Medicare,¹⁸¹ so the elderly

169. Democrat-Oregon.

170. Democrat-West Virginia.

171. H.R. 1515, 106th Cong. (1999).

172. See Bazelon Center, *Alert, "Parity" Bills Introduced in Both Houses* (visited Mar. 29, 2000) <<http://www.bazelon.org/499parit.htm>>. The bill would prohibit insurers from imposing inpatient hospital day and outpatient visit limits, or applying different deductibles, copayments, out of network charges or other financial requirements for mental health treatment. It would also amend the MHPA to eliminate the sunset provision and end the one percent cost increase exemption. *See id.*

173. See H.R. 1515, 106th Cong. (1999).

174. See Bazelon Ctr., *Legislative Update: First Session of 106th Congress Adjourned* (visited Mar. 29, 2000) <<http://www.bazelon.org/1299updt.html>>.

175. Republican-New Mexico.

176. Democrat-Minnesota.

177. S. 796, 106th Cong. (1999). See Thomas, *Mental Health Equitable Treatment Act of 1999*, (visited Mar. 29, 2000) <<http://thomas.loc.gov/cgi-bin/query/z?c106:S.796:>> (including the text of the bill).

178. See Bazelon Ctr., *supra* note 172. The Bill would provide equal copayments, deductibles, and other out of pocket costs, for schizophrenia, bipolar disorder, major depression, obsessive compulsive disorder, panic disorder, post traumatic stress disorder, autism, anorexia nervosa, and attention deficit/hyperactivity disorder. *See id.*

179. See *supra* note 122 and accompanying text.

180. See National Alliance for the Mentally Ill, *supra* note 108. See generally National Alliance for the Mentally Ill, *Senators Domenici and Wellstone Introduce Mental Health Equitable Treatment Act of 1999* (visited Mar. 29, 2000) <<http://www.nami.org/update/990416.html>>.

181. See Thomas, *supra* note 177.

are excluded from the mandate of parity. Like the bill introduced in the House, this bill is still in committee.¹⁸²

Within the scope of the MHPA, Congress should also consider an expansion of its application to include insurers other than large employer group health plans. The most notable insurer absent from the Act is Medicare. Thus, the Act does nothing to require parity for the elderly, and has eliminated remedy for that group.¹⁸³ This is especially shocking given that there are an estimated five million Medicare beneficiaries suffering from mental illness.¹⁸⁴ Legislation should be enacted to apply insurance benefits parity to Medicare as a means of effecting the intent of Congress and of eliminating the discriminatory effect the Act has forced upon the elder population.

An alternative, and perhaps more workable legislative proposal, is to amend the ADA to cover insurance disparity discrimination, in light of the decisions holding otherwise. The EEOC has already published revised guidance interpreting the ADA to prohibit disparate insurance benefits on the basis of disability. Given the broad sweep of the ADA, it seems inconsistent that it does not apply to discrimination in the insurance industry, yet applies to almost every other facet of society.

Specifically in relation to the elderly, a third legislative solution would involve a revision to the Medicare statute itself. Congress should amend the statute to increase the limits the statute imposes on mental health treatment benefits.¹⁸⁵ Given the large number of beneficiaries suffering from mental illness,¹⁸⁶ the inferior mental illness benefits of Medicare, and the failure of the MHPA to reach Medicare,¹⁸⁷ such an amendment would essentially eliminate the problems associated with the MHPA for most of the elderly.

This solution was embodied in Representative Stark's¹⁸⁸ sponsorship of the National Mental Health Parity Acts of 1996¹⁸⁹ and 1999,¹⁹⁰ both of which included provisions for the improvement of Medicare

182. See Bazelon Ctr., *supra* note 174.

183. See *supra* notes 127–29 and accompanying text.

184. See National Alliance for the Mentally Ill, *supra* note 108.

185. See *supra* notes 127–29, 150–51 and accompanying text.

186. See *supra* note 129 and accompanying text.

187. See *supra* note 121 and accompanying text.

188. Democrat-California.

189. H.R. 4045, 104th Cong. (1996).

190. H.R. 2593, 106th Cong. (1999).

mental health coverage.¹⁹¹ The bill would have, among other things, increased the scope of covered mental health services, increased inpatient day limits to numbers comparable to that of physical illness, and decreased the copayments of beneficiaries under Medicare.¹⁹² Neither bill, however, made it out of committee.¹⁹³

V. Conclusion

Senator Pete Domenici, sponsor of the Mental Health Parity Act, described its enactment as a “historic step, a breakthrough, for the severely mental ill . . . and Congress has taken one step to get rid of the terrible stigma and discrimination that is based on mystique, mystery, and Dark Age concepts.”¹⁹⁴ Despite these ostensibly noble intentions, Congress has created an unfortunate situation as a result of enacting the MHPA. Its application is minimal, and its ultimate effect has been to eliminate remedy for discrimination as a result of insurance benefits disparity. This effect is especially harsh for the elderly, who receive no facial benefit from the Act due to its inapplicability to Medicare, and who are now foreclosed from remedy for benefits disparity under the ADA. To reverse this unfortunate phenomenon, new legislation should be enacted to provide genuine parity between mental and physical illness insurance benefits, the Act should be amended to apply to Medicare, the ADA should be revised to apply to insurance benefits disparity, or Medicare should be amended to provide greater mental illness benefits. Without one or all of these changes, all benefi-

191. See Louis de la Parte Fla. Mental Health Inst., *Brief Legislative History of the Federal Parity Bill* (visited Mar. 29, 2000) <<http://www.fmhi.usf.edu/parity/legislativehis.html>> (detailing the 1996 act); 145 CONG. REC. E1637 (1999) (statement of Rep. Stark describing the 1999 act).

192. See Louis de la Parte Fla. Mental Health Inst., *Brief Legislative History of the Federal Parity Bill* (visited Mar. 29, 2000) <<http://www.fmhi.usf.edu/parity/legislativehis.html>> (detailing the 1996 act).

193. Rep. Stark afterward expressed his consternation with Congress's inaction:

The Majority also refuses to act on bills that increase the affordability and accessibility of mental health benefits to Americans. I have a bill, the National Mental Health Parity Act of 1999, that would require parity for physical and mental private health benefits and increase mental health benefits in Medicare. The Majority has refused to act on it or any other item. This bill is just one of many that attempt to ensure that Americans receive adequate mental health benefits.

146 CONG. REC. H2021 (2000).

194. See Gold, *supra* note 19, at 786 (quoting Robert Pear, *Conferees Agree on More Coverage for Health Care*, N.Y. TIMES, Sept. 20, 1996, at A1 (quoting Senator Domenici)).

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ciaries, and especially the elderly will be foreclosed from obtaining mental health benefits equal to physical health benefits.