

STOP THE BLEEDING: A CALL FOR CLARITY TO ACHIEVE TRUE MENTAL HEALTH PARITY

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“Parity - the quality or state of being equal: close equivalence or resemblance.”²

Tragic events at an elementary school in Newtown, Connecticut, and at a movie theater in Aurora, Colorado, have given rise to emotionally charged debates over issues ranging from gun control to the media’s role in sensationalizing extreme acts of violence.³ Citizens and politicians alike are beginning to recognize that these deeply troubling mass shootings are a national epidemic, and cannot be explained as random calamities or attributed to the culture of a particular region.⁴ Gun access and the media’s role in propagating the emotional contagion caused by extreme acts of violence have likely played a role in these horrific events, but any explanation as to how these acts of violence could occur is incomplete without examining the role of untreated mental illness.⁵

Until recently, a diagnosis of any mental illness ended the discussion as to why a violent actor would take innocent lives.⁶ Violent crimes, like those seen in Newtown and Aurora, were viewed as horrendous acts committed by sick individuals—end of story. Questions about why these sick individuals were left untreated went largely unexplored.⁷

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2. WEBSTER’S THIRD NEW INT’L DICTIONARY 1642 (1986).

3. *E.g.*, Thom Patterson, *Will Newtown change America’s attitude toward guns?*, CNN (Dec. 18, 2012, 11:15 AM), <http://www.cnn.com/2012/12/17/us/newtown-gun-control/>; Tom Curry, *NRA blames media, music and more for culture of violence*, NBC NEWS (Sept. 9, 2013, 9:21 AM), http://nbcpolitics.nbcnews.com/_news/2012/12/21/16069537-nra-blames-media-music-and-more-for-culture-of-violence?lite.

4. Alyssa Newcomb, *Mayor Michael Bloomberg Calls on Congress, President to End Gun Violence*, ABC NEWS (Dec. 17, 2012, 2:39 PM), <http://abcnews.go.com/blogs/headlines/2012/12/mayor-michael-bloomberg-calls-on-congress-president-to-end-gun-violence/>. Since 1982, at least sixty-two mass shootings have occurred in thirty states. Mark Follman et al., *A Guide to Mass Shootings in America*, MOTHER JONES, <http://www.motherjones.com/politics/2012/07/mass-shootings-map> (last updated Mar. 24, 2014).

5. *See* Andrew Beaujon, *How can we explain shootings if we don’t report on mental illness?*, POYNTER INST., <http://www.poynter.org/latest-news/mediawire/198261/how-can-we-explain-shootings-if-we-dont-report-on-mental-illness/> (last updated Dec. 17, 2012).

6. Andrew Beaujon, *Mental health reporters say Newtown shooting coverage shows progress*, POYNTER INST., <http://www.poynter.org/latest-news/mediawire/199090/mental-health-reporters-say-newtown-shooting-coverage-shows-progress/> (last updated Jan. 3, 2013).

7. *See id.*

With recent events, systemic failures in the treatment of mental illness are gaining some attention. First, reports about the University of Colorado safety committee's failure to follow up on warnings from James Holmes' psychiatrist have stirred debate as has to why severe mental illnesses are still being treated as less than serious diseases.⁸ Second, a woman frustrated by the options for mental health care in this country, and whose son has extreme behavioral issues, wrote one of the most-talked-about analyses that followed the Newtown tragedy.⁹ Third, following the events at Sandy Hook Elementary School, the Connecticut Office of the Health Care Advocate released a report calling the State's mental health care services "fragmented and inconsistent" and "largely . . . not integrated into overall healthcare models."¹⁰ Unfortunately, the flaws identified in Connecticut's mental health delivery system are not *sui generis*.¹¹ A nationwide failure to take substantive action to address the impact that mental illness thrusts upon the lives of everyday Americans has created an epidemic in need of serious attention.

For much of history, mental illness has been considered a character defect of the feeble-minded.¹² Such stigma has historically led to isolation of the mentally ill and has made access to effective and humane treatment difficult at best.¹³ Untreated mental illnesses have been associated with such life difficulties as school failure, poor employment opportunities, poverty, and high rates of incarceration.¹⁴ Research demonstrates that adults living with an

8. See Michael McLaughlin, *James Holmes' Psychiatrist Warned University Of Colorado He Might Be A Threat*, HUFFINGTON POST, http://www.huffingtonpost.com/2012/08/01/james-holmes-psychiatrist-threat_n_1731051.html (last updated Aug. 1, 2012).

9. Beaujon, *supra* note 6. For the complete essay, see Liza Long, *I Am Adam Lanza's Mother*, GAWKER (Dec. 16, 2012, 9:33 AM), <http://gawker.com/5968818/i-am-adam-lanzas-mother>.

10. Victoria Veltri, *Findings and Recommendations: Access to Mental Health and Substance Use Services*, OFFICE OF THE HEALTH CARE ADVOCATE vi (Jan. 2, 2013), http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf.

11. For discussions about systemic problems in delivering mental health services in other areas of the country see, e.g., Stephanie Brown, *'Woefully few resources' for NE Florida mental health*, WOKV (Dec. 25, 2012, 10:35 PM), <http://www.wokv.com/news/news/local/woefully-few-resources-ne-florida-mental-health/nTfgy/>; Andrew Stein, *Medical professionals say ER treatment for psychiatric patients is woefully inadequate*, VT DIGGER (Dec. 18, 2012, 4:48 AM), <http://vtdigger.org/2012/12/18/medical-professionals-say-er-treatment-for-psychiatric-patients-is-woefully-inadequate/>.

12. DEPT OF HEALTH AND HUMAN SERVS., *MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL* 6 (1999). See also C.A. Ross & E.M. Goldner, *Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature*, 16 J. PSYCHIATRIC & MENTAL HEALTH NURSING 558, 561 (2009) (finding that a large population of nurses to this day attribute mental illness to such factors "as weakness of morals, character or will; laziness; malingering; and the lack of discipline or self-control[]").

13. See EDWARD SHORTER, *A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC* viii-ix (1997).

14. Judith F. Cox et al., *A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems: Implications for Service Planning*, 28 J. BEHAV. HEALTH SERVS. & RES. 177, 182 (2001) (finding that People with untreated mental illnesses are four to six times more likely to be incarcerated); *Blueprint for Change: Research on Child and Adolescent Mental Health*,

untreated mental illness utilize more physical health care services, incur higher health care costs, and are more likely to present to emergency rooms for acute care.¹⁵

Discoveries in the past two decades demonstrating that biological factors play a significant role in the expression of all mental illnesses have fortunately helped those struggling with such illnesses to come out of the shadows and seek access to higher quality care.¹⁶ By 1996, seventy-four percent of Americans said that they supported equal access to mental health coverage in insurance plans.¹⁷ Such access is of monumental importance—it is currently estimated that one out of every two Americans will suffer from a mental illness at some point during their lives.¹⁸ Additionally, “mental illnesses account for more disability in developed countries than any other group of illnesses, including cancer and heart disease.”¹⁹

Historically, health insurance providers have offered far greater coverage for physical illnesses than for mental illnesses.²⁰ Health plans have limited treatment of mental illnesses by covering fewer inpatient hospitalizations and outpatient office visits, increasing cost sharing for mental health care by increasing deductibles and copays, and imposing more stringent annual or lifetime dollar limits on mental health coverage.²¹ State legislatures have chipped away at disparities in insurance coverage for mental and physical illnesses. Over the past two decades, forty-nine states and the District of Columbia have passed some form of mental health parity legislation.²² Congress has followed suit by enacting federal parity legislation.²³ Despite

NAT'L INST. OF MENTAL HEALTH 1 (2001), <http://wwwapps.nimh.nih.gov/ecb/archives/nimhblueprint.pdf>.

15. M. Philip Luber et al., *Depression and Service Utilization in Elderly Primary Care Patients*, 9 AM. J. GERIATRIC PSYCHIATRY 169, 169 (2001); Martin Knapp et al., *The Maudsley long-term follow-up of child and adolescent depression: Impact of comorbid conduct disorder on service use and costs in adulthood*, 180 BRIT. J. PSYCHIATRY 19, 19 (2002); *The Uninsured: The Impact of Covering Mental Illness and Addictions Disorders*, NAT'L COUNCIL FOR CMTY. BEHAV. HEALTHCARE (June 2007), <http://www.thenationalcouncil.org/wp-content/uploads/2012/12/CoveringTheUninsured.pdf>.

16. See Jason A. Seidel, *Experience is a biochemical intervention: Reconceptualizing the “biologically based mental illness,”* 69 BULL. MENNINGER CLINIC 157, 158 (2005).

17. Carolyn M. Levinson & Benjamin G. Druss, *The Evolution of Mental Health Parity in American Politics*, 28 ADMIN. & POL'Y MENTAL HEALTH 139, 139 (2000).

18. William C. Reeves et al., *Mental Illness Surveillance Among Adults in the United States*, 60 (Supp.) MORBIDITY & MORTALITY WKLY REP. 1, 2 (2011).

19. *Id.*

20. RAMYA SUNDARARAMAN & C. STEPHEN REDHEAD, CONG. RES. SERV., RL33820, THE MENTAL HEALTH PARITY ACT: A LEGISLATIVE HISTORY 1 (2008).

21. SUNDARARAMAN & REDHEAD, *supra* note 20, at 1.

22. Richard Cauchi et al., *State Laws Mandating or Regulating Mental Health Benefits*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> (last updated Jan. 2014).

23. See, e.g., Mental Health Parity Act of 1996 (“MHPA”), Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended 29 U.S.C. § 1185a (2006)); Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), Pub. L. No. 110-343, 122 Stat. 3881 (codified in large part at 29 U.S.C. § 1185a (2006)); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and

valiant efforts of some legislators, government actions have been thus far insufficient in achieving the equal treatment of mental and physical disorders, resulting in a large swath of the American population still living under the cloud of mental illness.

As a result of legislators' and regulators' failures to address which mental illnesses need to be covered, and which treatments should be offered for the covered disorders, millions of Americans are left untreated.²⁴ Contrary 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. Part I of this Note will give a brief history of legislative efforts to broaden mental health care, and the specific intents behind such legislation. Part II will analyze the effect mental health parity legislation has had on the delivery of mental health care, with special attention paid to how states define mental illness and medically necessary treatment. Part III will discuss how provisions within the Patient Protection and Affordable Care Act ("ACA") could affect the mental health care delivery system. Finally, Part IV of this Note will provide a regulatory framework that, if implemented, will help ensure that all Americans have access to quality mental health care services.

I. THE HISTORY AND INTENT OF FEDERAL PARITY LEGISLATION

Systemic problems in the treatment of mental illness were first recognized on a national level with the passage of The Mental Health Study Act of 1955.²⁵ The Act called for "an objective, thorough, and nationwide analysis and reevaluation of the human and economic problems of mental illness,"²⁶ and resulted in a 1963 report that painted a bleak picture of mental illness treatment in the United States.²⁷ Moved to take action by the results of the report, President John F. Kennedy delivered the first presidential address on mental health issues.²⁸ Under President Lyndon Johnson, financial resources were directed toward mental illness research, and developments in

Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. Relevant requirements of each of the aforementioned Acts are discussed *infra*.

24. *The Neglect of Mental Illness Exact a Huge Toll, Human and Economic*, THE SCIENTIFIC AM. (May 1, 2012), <http://www.scientificamerican.com/article.cfm?id=a-neglect-of-mental-illness>. Approximately only half of adults suffering from mental illness receive treatment in any given year. *Use of Mental Health Services and Treatment of Adults*, NAT'L INST. OF MENTAL HEALTH, http://www.nimh.nih.gov/statistics/3USE_MT_ADULT.shtml (last visited May 23, 2014).

25. Mental Health Study Act of 1955, Pub. L. No. 84-182, 69 Stat. 381 (no currently effective sections).

26. *Id.*

27. Stephen Satterfield, *A New Interpretation, an Absurd Result: How HHS is Short-Changing Children with Severe Mental Illness*, 77 GEO. WASH. L. REV. 1114, 1124 (2009).

28. *The NIH Almanac*, NAT'L INST. OF MENTAL HEALTH, <http://www.nih.gov/about/almanac/organization/NIMH.htm> (last visited May 23, 2014) [hereinafter *Almanac*]. Congress subsequently passed the Mental Retardation Facilities Construction Act, Pub. L. No. 88-164, 77 Stat. 282 (1963) (codified as 42 U.S.C. § 2661 (1973)), *superseded by* Pub. L. 94-103.

understanding disorder etiology were made.²⁹ Little was still being done legislatively, however, to increase patient access to care.³⁰

In 1977, President Jimmy Carter took a renewed interest in serving the mental health needs of the Nation and formed the President's Commission on Mental Health, which he charged with making recommendations on how to best serve the Nation's mental health needs.³¹ Taking action upon the Commission's recommendations, President Carter signed into law the Mental Health Systems Act.³² He described the Act as placing:

[s]pecial emphasis . . . on the care and treatment of chronic mental illness to ensure that mental health support and aftercare services are available at the community level. The act also provides Federal grants for the first time for projects to prevent mental illness and to promote mental health care. It also includes grants to initiate advocacy programs to protect the rights, the legal and other rights, of the mentally ill.³³

One year after the legislation was passed, President Ronald Reagan signed the Omnibus Budget Reconciliation Act of 1981, repealing the Mental Health Systems Act.³⁴ During the administrations of both Presidents Reagan and George H.W. Bush, the federal government, through block grants, provided states with technical assistance so that states could determine on their own how best to provide mental health services.³⁵ The federal government exerted little oversight over the allocation of such funds and did little to ensure that states had the capacity to provide the necessary mental health services.³⁶

In 1993, President Bill Clinton renewed efforts to impose greater federal involvement in the delivery of mental health services when he introduced his health care reform proposal, the Health Security Act.³⁷ Though the proposed legislation aimed to integrate the nation's mental health care system with that of acute physical care, the Bill limited mental health services in a way that it did not limit care for physical illnesses.³⁸ Nonetheless, the Bill had no impact—in 1994, it died in the Senate.³⁹

29. See Mental Health Amendments of 1967, Pub. L. No. 90-31, 81 Stat. 79.

30. See *Almanac*, *supra* note 28.

31. *Id.*

32. *Id.*

33. President Jimmy Carter, Mental Health Systems Act Remarks on Signing S. 1177 Into Law (Oct. 7, 1980) (transcript *available at* <http://www.presidency.ucsb.edu/ws/?pid=45228>).

34. *Almanac*, *supra* note 28.

35. See *id.*

36. *Accountability for Block Grants*, COMM. ON INSPECTION & EVALUATION: PRESIDENT'S COUNCIL ON INTEGRITY & EFFICIENCY ii (1996), <https://oig.hhs.gov/oei/reports/oei-01-96-00100.pdf>.

37. Bernard S. Arons et al., *Mental Health and Substance Abuse Coverage Under Health Reform*, HEALTH AFF., Spring 1994, at 192, 193.

38. See *id.* at 199-201 (describing what the mandatory mental health coverage under the Bill would be prior to 2001).

39. MARK E. RUSHEFSKY & KANT PATEL, POLITICS, POWER & POLICY MAKING: THE CASE OF HEALTH CARE REFORM IN THE 1990S 108 (1998).

Out of a growing need for mental health care access, and a lack of action by the federal government, states began to take matters into their own hands by demanding that insurance companies cover more mental health services. By 1996, seven states had enacted a form of mental health parity legislation.⁴⁰ Because of a growing trend at the state level, mental health advocates called on the federal government to enact legislation affecting employer-provided benefit plans regulated under the Employment Retirement Income Security Act (“ERISA”).⁴¹

A proposal by former Senator Peter Domenici (NM) and late Senator Paul Wellstone (MN) that would have “eliminated differential treatment of mental health conditions with regard to annual and lifetime dollar caps, inpatient and outpatient hospitalization limits, and coinsurance rates[]” passed the Senate.⁴² After strong lobbying by the business community, Congress passed a pared-down version of the Domenici-Wellstone proposal.⁴³ While the Act limited the ability of group health plans to place lower annual or lifetime money limits on mental health benefits than those of medical or surgical benefits, the broad access intent of the original proposal was narrowed to affect only plans that already offered mental health coverage.⁴⁴ Additionally, employers of fewer than fifty people were exempt from the law’s requirements.⁴⁵ While it may have been an important first step toward offering greater access to mental health services for some individuals, the Mental Health Parity Act (“MHPA”) could not reach the broad range of patients Senators Domenici and Wellstone had originally intended to reach.⁴⁶

A need for more extensive mental health parity legislation continued to draw Congress’ attention. During a House of Representatives Committee on Education and Labor Subcommittee on Health, Employment, Labor and Pensions hearing on July 10, 2007, Representative Patrick Kennedy from the First District of Rhode Island stated that a then newly proposed mental health parity bill would ensure that Americans in need of mental health and addiction treatment would receive coverage equal to that of members of Congress.⁴⁷ While members of Congress can choose from a variety of plans through the

40. 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, 764 (1997).

41. *Id.* at 766. Employer plans regulated by ERISA are not subject to individual state parity laws. 29 U.S.C. § 1144(a) (2006).

42. Jones, *supra* note 40, at 766-67.

43. 29 U.S.C. § 1185a (2006). For a discussion of the lobbying efforts that may have influenced the need to limit the Bill’s requirements, see Jones, *supra* note 40, at 767.

44. 29 U.S.C. § 1185a(a)(1)-(a)(2).

45. *Id.* at § 1185a(c)(1)(A)-(B).

46. In May 2000, the then-named United States General Accounting Office (“GAO”) found that despite increased parity offerings, the 1996 Act failed to increase employee health plan subscribers’ access to mental health care. U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-00-95, MENTAL HEALTH PARITY ACT: DESPITE NEW FEDERAL STANDARDS, MENTAL HEALTH BENEFITS REMAIN LIMITED 5 (2000).

47. EdLabor Democrats, *Mental Health Parity Hearing: Rep. Patrick Kennedy*, YOUTUBE (July 12, 2007), <http://www.youtube.com/watch?v=aMs319axN4k>.

Federal Employees Health Benefit Program, all offered plans provide significant mental health coverage.⁴⁸ As enacted, the Mental Health Parity and Addiction Equity Act (“MHPAEA”) did strengthen the MHPA by eliminating disparities between co-pays and deductibles for mental and physical illnesses for certain plans, but like its predecessor, the MHPAEA did not apply to small employee plans, nor plans that did not already offer mental health coverage.⁴⁹

Interestingly, this time around, lobbyists did not object, as expected, to the inclusion of coverage for substance abuse disorders in the proposed legislation but instead to a requirement that insurers cover treatment for any conditions listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (“DSM–IV–TR”), 4th ed., text rev. 2000.⁵⁰ Such a requirement was likely included in the original proposal so that insurance companies could not limit the types of mental disorders covered under any particular plan. Instead, the MHPAEA allows states and insurers to determine what constitutes a mental illness and, to a degree, how that illness is to be diagnosed.⁵¹ Additionally, although they now have to disclose their criteria for “medical necessity” when determining appropriate treatment for a mental illness, as well as provide a reason for denying a claim, a managed care company can still eliminate a form of treatment as being clinically inappropriate.⁵²

With the MHPAEA, Congress had an opportunity to achieve true parity, as was its intent, but it instead left the door open for the disparate treatment of mental and physical disorders. The promise to reach large numbers of Americans suffering from mental illness was getting closer, but the legislation still lacked the necessary teeth.

With the passage of the ACA, the MHPAEA was extended to individual plans, requiring that individual health insurance bought through state run “exchanges” offer mental health and addiction coverage at parity with physical illness coverage.⁵³ Beginning in 2014, insurance plans offered within the exchanges must cover an “essential health benefits” package that will be

48. BARBARA ENGLISH, CONG. RESEARCH SERV., RS21982, HEALTH BENEFITS FOR MEMBERS OF CONGRESS 1 (2007).

49. 29 U.S.C. § 1185a(a)(1)-(a)(2), (c)(1).

50. Robert Pear, *Equal Coverage for Mental and Physical Ailments Is Required in Bailout Law*, N.Y. TIMES, Oct. 6, 2008, at A13, A20.

51. The relevant Interim Rule states:

Any condition defined by the plan 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).

29 C.F.R. § 2590.712(a) (2010). Therefore, insurers can pick from a wide range of diagnostic tools in assessing whether a patient is living with a mental disorder.

52. Pear, *supra* note 50, at A20.

53. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. The mental health parity provisions of the Act go into effect in 2014. *Id.*

further defined by the Department of Health and Human Services (“HHS”).⁵⁴ Section 1302 of the ACA requires that mental health and substance use disorder services be considered as an essential benefit.⁵⁵ The requirement does not apply to large group, self-insured, or “grandfathered” plans that were in existence the date the ACA was enacted.⁵⁶

In making the case to extend mental health coverage under the ACA, HHS Secretary Kathleen Sebelius noted that in 2008, nearly ten million Americans did not receive the mental health services that they needed.⁵⁷ She further asserted, “[i]f 10 [million] . . . Americans were walking around bleeding, we’d have alarm bells going off”⁵⁸ Such a statement reveals that the Secretary believes mental illness to be akin to an acute trauma in need of immediate medical attention.

While the mental health parity provisions of the ACA have not yet gone into effect, it would seem that the Secretary believes that each of the ten million Americans in need of care should receive immediate treatment, yet no effort has been made to further clarify which disorders are to be covered under the Bill, nor which treatments are medically necessary. However, Congress has provided Secretary Sebelius with a framework that, if seriously funded and applied, has the potential to change the face of mental health care in this country.

II. MENTAL HEALTH PARITY LAWS IN PRACTICE

A. Problems in Defining Mental Illness

Due to the lack of specific direction from the federal government, states have defined mental illness in a variety of ways.⁵⁹ Some states have adopted language similar to that of federal legislation, leaving insurance companies to define which mental illnesses are deserving of equal treatment to physical disorders.⁶⁰ Others have taken it upon themselves to craft a definition of mental illness. As discussed below, both approaches can lead to further confusion and disparate treatment of mental illnesses.

54. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119, 163 (codified at 42 U.S.C. § 18022(b)(1) (Supp. V 2012)).

55. *Id.* at § 1302(b)(1)(E) (codified at 42 U.S.C. § 18022(b)(1)(E)).

56. *Id.* at § 1301(b)(1)(B) (codified at 42 U.S.C. § 18021(b)(1)(B) (Supp. V 2012)).

57. Meredith Cohn, *Sebelius Pushes for Health Bill: Sheppard Pratt Staff Hear from HHS Secretary*, BALT. SUN, Dec. 17, 2009, at A5.

58. Cohn, *supra* note 57.

59. Christopher John Churchill, *The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Federal Legislation*, 44 GA. L. REV. 511, 521 (2010).

60. *Id.*

1. The New England Problem

Connecticut and Vermont have taken a broad approach in defining mental illness, encompassing all disorders designated by a particular medical organization.⁶¹ While 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.⁶² For example, the DSM-IV-TR states that for a diagnosis of Bipolar I Disorder, the patient must have experienced at least one episode of mania lasting for at least a week;⁶³ the ICD-10, on the other hand, requires at least two mood disturbances, both of which may be mania.⁶⁴ While this may seem like an insignificant difference at first glance, it has implications as to when a patient suffering from bipolar disorder can begin to receive insured treatment. A manic episode can have a devastating impact on a patient's life; symptoms associated with mania "often lead to an imprudent involvement in pleasurable activities such as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the person, even though these activities are likely to have painful consequences"⁶⁵ Therefore, it stands to reason that a patient suffering from Bipolar I Disorder in Vermont would have to place their physical and financial health at serious risk for an extended period of time before they could receive covered treatment for their disorder. If that same patient were living in Connecticut, he would theoretically already be receiving treatment, and understand when to recognize the symptoms of his disorder.

Another New England state, New Hampshire, has made up its own definition of mental illness. New Hampshire defines a mental disorder as:

[A] clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.⁶⁶

61. *See, e.g.*, CONN. GEN. STAT. ANN. § 38a-514(a) (West, Westlaw through Pub. Acts of the 2013 Jan. Reg. Sess. of the Conn. Gen. Assemb.) (defining mental illness according to "the most recent edition of the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders'"); VT. STAT. ANN. tit. 8, § 4089b(b)(2) (West, Westlaw through the laws of the First Sess. of the 2013-2014 Vt. Gen. Assemb.) (defining mental illness as any "mental illness . . . that falls under any of the diagnostic categories listed in the mental disorders section of the [I]nternational [C]lassification of [D]isease[s] ['ICD-10'], as periodically revised[]").

62. *E.g., compare* WORLD HEALTH ORG., THE ICD-10 CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS (10th rev. 2010) [hereinafter ICD-10], *with* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text rev. 2000) [hereinafter DSM-IV-TR].

63. *See* DSM-IV-TR, *supra* note 62, at 357, 382.

64. ICD-10, *supra* note 62, at 97.

65. DSM-IV-TR, *supra* note 62, at 358.

66. N.H. REV. STAT. ANN. § 417-E:1(I) (West, Westlaw through Ch. 279 of the 2013

Despite New Hampshire's efforts to make clear which types of illnesses mandate coverage, at least one insurance provider within the State utilizes its own definition in reviewing claims. In *Hunt v. Golden Rule Ins. Co.*, the court noted that the insurance policy at issue defined mental illness as "neurosis, psychoneurosis, psychopathy, psychosis, or [a] mental or emotional disease or disorder of any kind."⁶⁷ While the insurance provider's definition is broad enough to fit within the State's definition of mental illness, it elucidates the fact that there is little current guidance as to what exactly constitutes a mental illness. New Hampshire does maintain a list of disorders that are required to be covered under its definition, but the disorders covered that have not been enumerated will likely be the source of future litigation.⁶⁸ Such litigation will require that the courts interpret which illnesses are to be covered under the various definitions of mental illness.

2. Problems West of the Mississippi

A wide range of states avoid defining mental illness altogether, and instead limit mental health coverage to only those illnesses placed on an enumerated list.⁶⁹ Many states attempt to differentiate between mental disorders that are biologically and non-biologically based.⁷⁰ Still, other states attempt to limit coverage to those illnesses that they deem to be "severe."⁷¹ Nevada provides parity to only those disorders which it believes to be "biologically-based and, therefore, severe: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive

Reg. Sess.).

67. *Hunt v. Golden Rule Ins. Co.*, No. 109CV00051, 2009 WL 4762782, at 3 n.1 (D.N.H. Oct. 21, 2009). It is interesting that the insurance company chose to cover "psychopathy," as it was once considered by many mental health practitioners to be an untreatable disorder. Randall T. Salekin et al., *Treatment of Psychopathy: A Review and Brief Introduction to the Mental Model Approach for Psychopathy*, 28 BEHAV. SCI. & L. 235, 235 (2010). However, new research has demonstrated some modest findings about the utility of psychotherapeutic techniques with populations affected by this disorder—especially if the trait is identified in childhood. *Id.* Of further interest, New Hampshire is not one of the thirty states that was forced to cope with a recent mass shooting within its borders. While causation of such a non-event cannot be attributed to the language in insurance policies operating within the state, the effects of singling out this disorder in definitions of mental illness warrants further research and discussion—especially in light of the recent tragic events in Newtown and Aurora.

68. N.H. REV. STAT. ANN. § 417-E:1(III). Interestingly, the list of covered disorders changed three times in 2002, but has not been updated since. N.H. REV. STAT. ANN. § 417-E:1 editor's and revisor's notes (West 2012).

69. Churchill, *supra* note 59, at 522. Twenty-two states utilize this approach in some form. *Id.*

70. Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL'Y 455, 497 (2011). Though such a discussion is beyond the scope of this Note, classifying mental disorders as non-biologically based has been demonstrated to be a fallacy. *See, e.g.*, Seidel, *supra* note 16, at 157 (finding that "mental disorders are biologically expressed, not epiphenomenal to a biological process[]").

71. Tovino, *supra* note 70, at 497.

disorder.”⁷² Interestingly, absent from the list are disorders such as anorexia nervosa, autism, and posttraumatic stress disorder. Perhaps the State of Nevada does not believe that such disorders deserve equal treatment to physical disorders because they are not “severe” or “biologically-based.”

Similarly, South Dakota covers only “schizophrenia and other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder.”⁷³ Louisiana’s list of covered disorders is lengthy in comparison, but still limits coverage to thirteen specific disorders, including “intermittent explosive disorder” and “panic disorder.”⁷⁴ Absent from the list are illnesses such as general anxiety disorder and specific phobia, despite the fact that these disorders are synonymous with extreme biological reactivity.⁷⁵

3. A Problem Left for the Courts

Because the federal government has not offered a clear guideline as to what exactly constitutes a mental illness, courts are beginning to have to examine the issue. In a recent appeal from the New Jersey State Health Benefits Commission's determination that agenesis of the corpus callosum (ACC) was not a biologically-based mental illness deserving of coverage, the court remanded the case and held that more expert testimony should be allowed so that the Commission could make a well-informed decision.⁷⁶ In *DeVito v. Aetna, Inc.*, the court allowed plaintiff's action, which alleged that the defendant denied claims for the treatment of an eating disorder because it believed the eating disorder to be non-biologically based, to proceed to trial.⁷⁷ The court did not make a determination as to the biological basis, and the case has had no subsequent written opinions.

While the courts have thus far avoided making a determination as to which disorders constitute a mental illness, they will likely continually face the question until the federal government offers some substantive guidance. If forced to make a determination, it is likely that the various courts will define mental illness almost as differently as have the various state legislators and insurance providers. An additional problem for federal courts is deciding whose definition of mental illness applies, as the current language of the relevant federal regulation allows both states and insurance companies to define mental illness. As the facts in *Hunt* reveal, states and insurance companies can maintain different definitions of mental illness for determining

72. Tovino, *supra* note 70, at 497 (citing NEV. REV. STAT. ANN. § 689A.0455(8)(a)-(f) (2009)).

73. S.D. CODIFIED LAWS § 58-18-80 (West, Westlaw through the 2013 Reg. Sess.).

74. LA. REV. STAT. ANN. § 22:1043(A)(1)(b)(i)-(b)(xiii) (West, Westlaw through the 2013 Reg. Sess.).

75. See O Brawman-Mintzer & R.B. Lydiard, *Biological basis of generalized anxiety disorder*, J. CLINICAL PSYCHIATRY, 1997, at 16, 16 (finding that extreme biological/chemical responses to stress are found in patients suffering from general anxiety disorder).

76. *J.S. v. State Health Benefits Comm'n*, 2010 WL 770978, at *5 (N.J. Super. Ct. App. Div. Mar. 4, 2010).

77. 536 F. Supp. 2d 523, 532-33 (D.N.J. 2008).

coverage. For private employee benefit plans subject to ERISA preemption of state law, a federal court has little direction as to whose definition to utilize if it were forced to determine whether any particular illness should be covered under federal mental health parity laws.⁷⁸

As the above discussed state legislation demonstrates, there is a lack of clarity as to what constitutes a mental illness, and therefore, which illnesses should be subject to federal parity legislation. It is understandable that states have an interest in keeping health insurance costs at a minimum by limiting the illnesses subject to parity legislation, but mental illnesses will never be treated equally to physical illnesses (such as cancer) if insurance companies and various state legislators continue to craft their own definitions of mental illness. Therefore, it is crucial that the federal government crafts a specific definition of mental illness to achieve its stated goal of true mental health parity.

B. Problems in Determining Medical Necessity

The standard many insurance providers utilize in determining whether to extend a benefit for treatment of a given illness is “medical necessity.”⁷⁹ The rules governing the MHPAEA offer no guidance as to how the determination is to be made when deciding coverage for mental illness, other than benefits must “be consistent with generally recognized independent standards of current medical practice”⁸⁰ The glossary to the relevant ACA rules defines 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.”⁸¹ While codifying acceptable forms of treatment for every mental illness would be a cumbersome task that could potentially hinder individually-focused treatment, more treatment guidance is necessary because courts, states, and insurance companies often differ as to what constitutes medical necessity.

Some states, such as California, have already listed which types of treatment are to be covered for physical illnesses, and have applied the same standard to mental health care. California Health & Safety Code Section 1345(b) provides the following health care services as “basic”:

- (1) Physician services, including consultation and referral[;]
- (2) Hospital inpatient services and ambulatory care services[;]
- (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services[;]
- (4) Home health services[;]
- (5) Preventive health services[;]
- (6) Emergency health care services, including

78. ERISA regulates the majority of private employee medical benefit plans. Churchill, *supra* note 59, at 525.

79. See Pear, *supra* note 50, at A20.

80. 29 C.F.R. § 2590.712(a) (2012).

81. Glossary of Health Insurance and Medical Terms, 76 Fed. Reg. 52529 (Aug. 22, 2011).

ambulance and ambulance transport services and out-of-area coverage . . . [;] (7)
Hospice care pursuant to Section 1368.2.⁸²

A question arises as to whether such a list is exhaustive, and to whether applying a list of treatments designed for physical illnesses to mental illnesses facilitates true equal treatment. Without considering the unique nature of mental health care services, some medically necessary treatments are not likely to be found on a list such as the one in the California statute.

In *Harlick v. Blue Shield of California*, the United States Court of Appeals for the Ninth Circuit held that under California's mental health parity law, all forms of medically necessary treatment must be covered for mental illnesses.⁸³ The plaintiff sought recovery from her insurance provider for the expenses for inpatient, "residential" care of her anorexia nervosa when she was at sixty-five percent of her ideal body weight and required a feeding tube.⁸⁴ The court fell short of concluding whether or not residential care was medically necessary for the plaintiff's condition because it held that the defendant was foreclosed from making the claim.⁸⁵

The court did find that the list of treatments provided in the state law was not exhaustive, and it suggested that residential treatment of anorexia crosses the medical necessity threshold.⁸⁶ The court reasoned that a violation of the mental health parity statute can be established by demonstrating that a health care insurance provider either denies coverage for a medically necessary treatment specific to a plaintiff's illness or by showing that the provider "categorically denies coverage for mental health care services that may, in some circumstances, be medically necessary"⁸⁷ The Ninth Circuit noted, however, that at least two district courts have concluded that the wording of the California statute means that the list of benefits is exhaustive.⁸⁸ Other courts applying the California law have refused to look at the issue.⁸⁹ Where California intended to offer guidance, it instead has created more confusion. Unless the federal government provides clear and specific guidelines, similar legal issues are foreseeable for courts deciphering medical necessity as applied to federal parity legislation.

Wisconsin has severely limited the treatments it deems medically appropriate for the treatment of mental illness. The state's BadgerCore Plus plan for childless low-income adults provides unlimited visits to psychiatrists

82. CAL. HEALTH & SAFETY CODE § 1345(b) (West, Westlaw through all 2013 Reg. Sess. Laws).

83. 686 F.3d 699, 719 (9th Cir. 2012).

84. *Id.* at 704-06.

85. *Id.* at 721.

86. *Id.*

87. *Id.* at 716 (quoting *Arce v. Kaiser Found. Health Plan, Inc.*, 104 Cal. Rptr. 3d 545, 565 (Cal. Ct. App. 2010)).

88. *Id.* at 712 (citing *Daniel F. v. Blue Shield of Cal.*, No. C09-2037, 2011 WL 830623, at *8-9 (N.D. Cal. Mar. 3, 2011); *Wayne W. v. Blue Cross of Cal.*, No. 1:07-CV-00035, 2007 WL 3243610, at *4 (D. Utah Nov. 1, 2007)).

89. See, e.g., *Arce*, 104 Cal. Rptr. 3d at 555 (quoting the trial court's finding that it "cannot determine what is 'medically necessary[]'").

and for medication, but provides no reimbursement or coverage for therapy provided by psychologists, social workers, or other mental health professionals.⁹⁰ Additionally, the plan does not provide for inpatient hospitalization coverage for mental illness or addiction, though such hospitalization is covered for other disorders.⁹¹ Despite calls from advocates that the plan violates parity laws, Wisconsin officials state that “[t]he parity law does not require plans that provide [mental health and substance abuse disorder] benefits to provide access to all services for those conditions[]”⁹² The plan has yet to be challenged in the courts.

Because of a lack of guidance in parity legislation and the relevant rules, medically necessary treatment for a person suffering from anorexia nervosa and living at sixty-five percent of their ideal body weight in California could look vastly different from the care provided to that same person if they lived in Wisconsin. The patient in California would be covered for full residential care in treating her illness, while the patient in Wisconsin may only be covered for prescription medication and outpatient visits to a psychiatrist. It is unlikely that disparities of this magnitude exist between states for which treatments are covered for any physical disorder. Therefore, to achieve true parity, especially in the face of increased federal involvement in individual health plans, the federal government needs to offer guidance as to what constitutes medically necessary treatments for mental disorders.

III. IMPLICATIONS OF THE ACA

A. Expanding Coverage

With the passage of the ACA, the MHPAEA was extended to individual plans, requiring that individual health insurance bought through state run “exchanges” offer mental health and addiction coverage at parity with physical illness coverage.⁹³ Beginning in 2014, insurance plans offered within the exchanges must provide a package of ten essential health benefits (“EHBs”), including mental health and substance use disorder services.⁹⁴ Additionally, the law explicitly outlines that the EHBs must “take into account the health care needs of diverse segments of the population, including . . . persons with disabilities”⁹⁵ The EHB requirement does not apply to large group, self-

90. Shawn Doherty, *Plan might violate mental health parity law*, MADISON CAPITAL TIMES (Dec. 6, 2009, 10:30 AM), http://host.madison.com/ct/news/local/health_med_fit/article_9af8a54e-17b0-5721-9c9e-94aaef43b484.html.

91. *Id.*

92. *Id.* (quoting an email from spokeswoman Stephanie Smiley).

93. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834 (Feb. 25, 2013). The mental health parity provisions of the Act go into effect in 2014. *Id.*

94. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1302(b)(1), 124 Stat. 119, 163-64 (codified at 42 U.S.C. § 18022(b)(1)).

95. *Id.* at § 1302(b)(4)(C) (codified at 42 U.S.C. § 18022(b)(4)(C)).

insured, or “grandfathered” plans that were in existence prior to the ACA’s enactment.⁹⁶

On February 25, 2013, HHS offered its Final Rule concerning EHBs.⁹⁷ It confirmed that the EHB requirement will have to comply with the MHPAEA, but did not further define mental illness or the treatments to be covered.⁹⁸ Secretary Sebelius gave each state the authority to choose an existing insurance plan to act as a specific benchmark for provided services.⁹⁹ It remains unclear as to how benchmark plans will affect treatments to be covered by insurance providers for specific disorders. By allowing states the flexibility to interpret how EHBs are packaged and sold, the disparate diagnostic qualifications for mental disorders and the corresponding fragmented treatment modalities will likely continue.

Even without a clear working definition of mental disorders, the mental health and substance use disorder EHB provisions of the ACA will likely help many of those currently without mental health coverage gain access to some form of mental health services; coverage of mental health care services will be expanded and denial of coverage for preexisting conditions will be prohibited.¹⁰⁰ However, the difficulties in defining illness and proper care, as discussed in Part II, will likely persist if HHS offers no further clarification.

With some exceptions, insurance providers will have to comply simultaneously with the ACA, the MHPAEA, and any state laws that demand more comprehensive coverage.¹⁰¹ Since state legislators and regulators are often the only groups that have attempted to offer a legal definition of mental illness and its corresponding treatments, without further action, mental health coverage will remain, as the Connecticut Office of the Health Care Advocate astutely observed, “fragmented and inconsistent” and “largely . . . not integrated into overall healthcare models.”¹⁰²

Interestingly, in a Final Rule published preceding the codified EHB Final Rule, it was noted that a study of implementation of parity in certain federal health insurance plans, “as well as research into state-passed mental health parity laws have shown little or no increase in utilization of mental health

96. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1301(b)(1)(B), 124 Stat. 119, 163-64 (codified at 42 U.S.C. § 18021(b)(1)(B)).

97. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. at 12834.

98. *Id.*

99. 42 C.F.R. § 440.330(d) (2012).

100. 42 U.S.C. § 300gg-3(a) (Supp. V 2012) (“A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.”).

101. Compare 29 U.S.C. § 1185a (2006), with Patient Protection and Affordable Care Act of 2010, 1501, Pub. L. No. 111-148, §§ 1321(d), 124 Stat. 119, 186, for a general understanding of the requirements of mental health coverage in each state and which plans are affected.

102. Veltri, *supra* note 10, at vi.

services”¹⁰³ While such findings should give regulators pause, HHS did not take note of the potential reasons why parity laws have thus far been ineffective in expanding access to mental health care.

The National Institute of Mental Health (“NIMH”) appears to have recognized that a barrier to mental health treatment is the lack of medical clarity in diagnosing mental illness. NIMH announced this month that it will begin a decade-long project to research mental disorders by biomarkers, with the hope of incorporating genetics, brain imaging, and physiological data into a set of diagnostic procedures.¹⁰⁴ Such research may fundamentally alter clinical understanding of mental disorders and limit the utility of DSM diagnostic criteria.¹⁰⁵ However, in the face of government spending cutbacks, the fruits of NIMH research may not be seen for decades to come.¹⁰⁶

B. Preference-Sensitive Care

In an attempt to incorporate patient preferences and values into medical plans, the ACA mandates the use of decision aids for preference-sensitive care.¹⁰⁷ Preference-sensitive care is defined in the ACA as:

medical care for which the clinical evidence does not clearly support one treatment option such that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregivers or authorized representatives regarding the benefits, harms and scientific evidence for each treatment option, the use of such care should depend on the informed patient choice among clinically appropriate treatment options.¹⁰⁸

Decision aids are “written materials, videos, or interactive electronic presentations designed to inform patients and their families about care options; each option's outcomes, including benefits and possible side effects; the health care team's skills; and costs.”¹⁰⁹

Typically, physical illnesses such as prostate cancer, chronic stable angina, and herniated discs are viewed as conditions that warrant the use of preference-sensitive care, because there are trade-offs with each of the

103. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12861 (Feb. 25, 2013) (footnote omitted).

104. Stephanie Pappas, *National Institute Of Mental Health To Drop DSM Use*, HUFFINGTON POST (May 3, 2013), http://www.huffingtonpost.com/2013/05/03/national-institute-of-mental-health-dsm-use_n_3211440.html.

105. *Id.*

106. *See id.*

107. 42 U.S.C. § 299b-36(c)(1)(A) (Supp. V 2012).

108. *Id.* at § 299b-36(b)(2) (footnote omitted).

109. Emily Oshima Lee & Ezekiel J. Emanuel, *Shared Decision Making to Improve Care and Reduce Costs*, 368 NEW ENG. J. MED. 6, 6 (2013).

treatment options.¹¹⁰ Furthermore, evidence does not clearly support the use of one acceptable treatment option over another.¹¹¹

Despite an increasingly growing body of evidence demonstrating that medication and “talk therapies” are both effective in treating a variety of mental illnesses, such illnesses are surprisingly absent from those that generally warrant preference-sensitive care.¹¹² Certainly the side effects of medication and intensive talk therapy—as well as the effect each has on quality of daily life—are unique enough to offer distinct advantages and disadvantages.

Secretary Sebelius has been presented with an opportunity to consider the inclusion of some mental illnesses on the list of disorders that warrant the use of decision aids under the ACA. Empirically supported decision aids already exist in formats ranging from DVD to web-based programs for such common mental disorders as generalized anxiety and depression.¹¹³

C. Improving Quality of Mental Health Care

The ACA has several quality control provisions that have the potential to reinforce the utility of various psychotherapies in treating mental illness. First, the Patient-Centered Outcomes Research Institute (“PCORI”) is established to:

assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in

110. Douglas S. Wakefield & Bonnie J. Wakefield, *The Complexity of Health Care Quality*, in JONAS & KOVNER’S HEALTH CARE DELIVERY IN THE UNITED STATES 408, 420 (Anthony R. Kovner et al. eds., 9th ed. 2008).

111. *Id.*

112. NIMH has identified several mental disorders in which both medication and more traditional forms of psychotherapy are effective forms of treatment. See, e.g., Press Release, Nat’l Inst. of Mental Health, Intensive Psychotherapy More Effective Than Brief Therapy for Treating Bipolar Depression (Apr. 2, 2007), <http://www.nimh.nih.gov/science-news/2007/intensive-psychotherapy-more-effective-than-brief-therapy-for-treating-bipolar-depression.shtml> (finding that a combination of intensive psychotherapy and medication to be the most effective treatment for bipolar disorder); *Eating Disorders*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/eating-disorders/how-are-eating-disorders-treated.shtml> (last visited May 23, 2014) (discussing the effectiveness of both cognitive-behavioral therapy (CBT) and Prozac in treating bulimia nervosa); *Depression*, NAT’L INST. OF MENTAL HEALTH 16, <http://www.nimh.nih.gov/health/publications/depression/depression-booklet.pdf> (last visited Jan. 12, 2014) (discussing the effectiveness of CBT and interpersonal therapy (IPT), as well as the effectiveness of various medications and electroconvulsive therapy (ECT) in treating depression). For a more in depth discussion of the research behind psychotherapeutic treatments for disorders ranging from post-traumatic stress disorder to couple’s distress, see generally CLINICAL HANDBOOK OF PSYCHOLOGICAL DISORDERS: A STEP-BY-STEP TREATMENT MANUAL (David. H. Barlow ed., 4th ed. 2007).

113. See, e.g., *Treatment for Anxiety*, INFORMED MED. DECISIONS FOUND., http://informedmedicaldecisions.org/imdf_decision_aid/treatment-for-anxiety/ (last visited Jan. 14, 2014) (on file with Widener Law Review).

patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, [and] services¹¹⁴

PCORI research findings must be released within ninety days and they must be made available to clinicians, patients, and the general public.¹¹⁵ Clinical guidelines are to be developed taking into consideration the research on outcome measures and best practices.¹¹⁶ Unfortunately, the ACA prohibits using PCORI research findings as mandates for “practice guidelines, coverage recommendations, payment, or policy recommendations”¹¹⁷ Though all significant research findings should not be immediately incorporated into practice guidelines without further critical analysis, the wording of the law would allow Secretary Sebelius to continue to evade incorporating effective psychotherapeutic techniques into best practice guidelines.

Nonetheless, the innovative health care structures envisioned by Congress give reason to hope that psychotherapeutic techniques validated by research will be incorporated into best mental health practices. Such tools can assist Secretary Sebelius in crafting more comprehensive definitions as to what constitutes a mental illness, and which treatments should be provided for such conditions.

The ACA also addresses concerns over emergency mental health services offered to Medicaid enrollees, as Medicaid does not currently reimburse psychiatric institutions for services provided to enrollees between the ages of twenty-one and sixty-four.¹¹⁸ Due to the exclusion, many Medicaid enrollees with acute psychiatric needs, such as those that pose a present danger to themselves or others, “are diverted to general hospital emergency departments, which often lack the resources or expertise to care for these patients.”¹¹⁹ For the Medicaid patient, this may result in delayed and inadequate treatment.

In an attempt to address concerns surrounding this issue, legislators established the Medicaid Emergency Psychiatric Demonstration under Section 2707 of the ACA.¹²⁰ Eleven states and the District of Columbia will participate in the demonstration program that will “test whether Medicaid can support higher quality care at a lower total cost by reimbursing private psychiatric hospitals” for emergency psychiatric care.¹²¹ The Centers for Medicare and Medicaid Services (“CMS”) will provide up to seventy-five million dollars in federal Medicaid matching funds to participating states over

114. 42 U.S.C. § 1320e(c) (Supp. V 2012).

115. *Id.* at § 1320e(d)(8)(A).

116. *See id.* at § 1320e(d)(8)(A)(i)-(ii).

117. *Id.* at § 1320e(d)(8)(A)(iii-iv).

118. *Medicaid Emergency Psychiatric Demonstration*, CTMS. FOR MEDICARE & MEDICAID SERVS., <http://innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/> (last visited May 23, 2014).

119. *Id.*

120. *Id.*

121. *Id.* The participating states are Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia. *Id.*

three years.¹²² CMS is also required to submit a report to Congress at the end of 2013 that independently analyzes the effectiveness and cost efficiency of the demonstration.¹²³ Congress will then determine whether to expand the reimbursement model nationally.¹²⁴

Such a change in how Medicaid delivers inpatient psychiatric care could lead to improvements in emergency mental health systems. However, some mental health experts have expressed concerns that state hospitals are unable to participate in the demonstration.¹²⁵ Medicaid reimbursement to state psychiatric hospitals could potentially be linked to better outcomes than those found for private institutions, because state hospitals are well connected to community-based services and are better able to coordinate maintenance treatment through day treatment programs.¹²⁶

D. Preventive Care

ACA provisions that focus on preventive care will potentially lead to earlier identification of mental disorders that warrant treatment. The United States Preventive Services Task Force (“USPSTF”) has been commissioned to identify clinical preventive health care services – such as screening, counseling, and preventive medications – that are required to be covered by insurance providers without cost-sharing.¹²⁷ A plan offering group or individual health coverage must provide, with no cost-sharing, evidence-based screening items and health services that the USPSTF rates as an “A” or a “B.”¹²⁸ Thus far the USPSTF has provided a “B” rating recommendation to the following preventive services directly related to mental health: depression screenings for both adults and adolescents, and alcohol misuse screening and counseling for adults.¹²⁹

Mandating insurance coverage of these mental health screening tools effectively expands the list of medically necessary treatments for depression and alcohol misuse. The Task Force’s attention to these mental disorders is a promising sign that assessment tools for other mental disorders will receive consideration as part of a medically necessary early-detection treatment.

122. *Medicaid Emergency Psychiatric Demonstration*, *supra* note 118.

123. *Medicaid Emergency Psychiatric Demonstration: Demonstration Design and Solicitation*, CTRS. FOR MEDICARE & MEDICAID SERVS. 9, http://innovation.cms.gov/Files/x/MedicaidEmerPsy_solicitation.pdf (last visited May 23, 2014).

124. *See id.*

125. Sarah Barr, *Feds To Test Paying For Medicaid Patients With Psychiatric Emergencies*, CAPSULES: THE KHN BLOG (Mar. 23, 2012, 3:09 PM), <http://capsules.kaiserhealthnews.org/index.php/2012/03/feds-to-test-paying-for-medicare-patients-with-psychiatric-emergencies/>.

126. *See id.*

127. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2713(a)(1), 124 Stat. 119, 131 (codified at 42 U.S.C. § 300gg-13 (Supp. V 2012)).

128. *Id.*

129. *USPSTF A and B Recommendations*, U.S. PREVENTIVE SERVS. TASK FORCE, <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> (last visited May 23, 2014).

E. Service Provider Issues

Two ACA provisions that may increase the need for mental health care workers beyond that anticipated for coverage expansion are “[r]ewarding quality through market-based incentives”¹³⁰ requirements and the Medicare Hospital Readmissions Reduction Program.¹³¹ The HHS Secretary is required to develop guidelines for the periodic reporting to the Exchanges about: “the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional[.] . . .”¹³² Additionally, beginning in the 2013 fiscal year, inpatient hospitals enrolled in Medicare’s Prospective Payment System (“PPS”) that maintain higher than expected readmissions rates will experience decreased Medicare payments for all Medicare discharges.¹³³ Performance evaluation will be based on the thirty-day readmission measures for heart attack, heart failure, and pneumonia.¹³⁴ Beginning in 2015, the Secretary is able to expand the list of conditions to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures, as well as any other condition or procedure the Secretary chooses.¹³⁵

Because psychological disorders have been associated with poor patient outcomes following hospitalization for such medical conditions as coronary heart disease,¹³⁶ hospitals may look to mental health professionals in helping patients maintain treatment compliance and to work through any issues stunting recovery after discharge.

The ACA could greatly increase demand for mental health care professionals. It is estimated, however, that approximately ninety million Americans live in designated mental health care shortage areas compared with approximately fifty-six million living in primary care shortage areas.¹³⁷ In an effort to reduce shortages in the wake of growing demand for mental health services, the ACA provides for expanded loan repayment programs, training grants, and expansions of the National Health Service Corp to recruit, among others, mental health professionals to medically underserved areas.¹³⁸

130. 42 U.S.C. § 18031(g) (Supp. V 2012).

131. 42 U.S.C. § 1395ww(q) (Supp. V 2012).

132. 42 U.S.C. § 18031(g)(1)(B) (Supp. V 2012).

133. *Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care*, AM. HOSP. ASS’N 1 (Sept. 2011), www.aha.org/research/reports/tw/11sep-tw-readmissions.pdf.

134. *Id.* at 3.

135. *Id.*

136. *See, e.g.*, Nancy Frasure-Smith et al., *Depression and health-care costs during the first year following myocardial infarction*, 48 J. PSYCHOSOMATIC RES. 471, 476 (2000).

137. Paige Winfield Cunningham, *Loophole for mental health care*, POLITICO (Mar. 4, 2013), <http://dyn.politico.com/printstory.cfm?uuid=A2317723-3839-4A54-9072-11D072634269>.

138. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 5207, 124 Stat. 119, 612 (codified at 42 U.S.C. § 254q(a) (Supp. V 2012)).

While such benefits and recruitment may help increase the number of mental health professionals entering the workforce, many such professionals will not likely accept private insurance, as reimbursement rates are too low and the paperwork is too cumbersome.¹³⁹ Psychiatrists and mental health professionals who treat children are among the least likely to accept private insurance.¹⁴⁰ Therefore, private insurance providers may have already identified a “loophole” to mental health parity requirements under the ACA: limit treatment modalities and keep reimbursement rates so low as to turn off providers.¹⁴¹

Accordingly, the expansion of mental health care coverage could be severely limited if action is not taken by Congress to restructure reimbursement of behavioral health services. However, if mental health care professionals are more well-integrated into patient discharge planning by hospitals, it is foreseeable that such professionals would enjoy stronger and more cohesive bargaining power in renegotiating reimbursement rates and treatment options with private insurers.

IV. RECOMMENDATIONS

A. Defining Mental Illness

Without further guidance from HHS, it is unlikely that insurance providers will adopt a uniform definition of mental illness that will capture the manifold disorders that affect millions of Americans each year. The DSM is highly relied upon by the mental health services community as the “bible”¹⁴² of psychological and psychiatric diagnosis, and states such as Connecticut—which consider all illnesses identified within the diagnostic manual to satisfy the definition of mental illness—theoretically offer comprehensive coverage. However, the American Psychiatric Association, the publisher of the manual, has come under heavy criticism for being “stubbornly committed to increasing the prevalence of mental illness.”¹⁴³ Others have criticized the Association’s ties to the pharmaceutical industry and the alleged secrecy with which the

139. Cunningham, *supra* note 137.

140. Ed Stannard, *Shortage of child psychiatrists has families scrambling for help*, NEW HAVEN REGISTER, Jan. 20, 2013, at A1.

141. Cunningham, *supra* note 137.

142.

It is as important to psychiatrists as the Constitution is to the US government or the Bible is to Christians. Outside the profession, too, the DSM rules, serving as the authoritative text for psychologists, social workers, and other mental health workers; it is invoked by lawyers in arguing over the culpability of criminal defendants and by parents seeking school services for their children.

Gary Greenberg, *The Book Of Woe: Inside the struggle to define mental illness*, 19 WIRE, Jan. 2011.

143. Johnathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL’Y 181, 265 (2011).

DSM task force conducts research and compiles scientific data.¹⁴⁴ While such concerns may be warranted, they are not unique to the fields of psychiatry and psychology. Criticisms of research methodology and pharmaceutical influence pervade almost every medical practice area.¹⁴⁵

Though the NIMH initiative researching “biological” markers for diagnosing mental illness may eventually inform and change diagnostic tools, the DSM-V, published in May 2013, will almost certainly provide the framework by which the majority of mental health practitioners diagnose, bill, and communicate with one another for quite some time. Therefore, Secretary Sebelius should craft a definition of mental illness that incorporates all disorders recognized by the American Psychiatric Association.

Illnesses found to be most prevalent, or those for which the severity of symptoms have a reasonable probability of manifesting behaviors that pose great danger to the patient’s or another’s life, should be highlighted as illnesses for which periodic primary care screenings are warranted. To reduce pharmaceutical influence in crafting diagnoses, Congress should place limits on the amount of income or other benefits anyone on a diagnostic task force, such as those on the DSM task force, can receive from companies that have a major stake in the task force’s findings.

B. Determining Medical Necessity

Provisions within the ACA promise to expand current understandings of medically necessary treatment for mental disorders, but a great body of evidence already exists validating traditional psychotherapeutic techniques in

144. See generally Cia Bearden, *The Reality of the DSM in the Legal Arena: A Proposition for Curtailing Undesired Consequences of an Imperfect Tool*, 13 HOUS. J. HEALTH L. & POL’Y 79 (2012) (discussing the many criticisms with which the various editions of the DSM has been subjected).

145. See, e.g., Troyen A. Brennan et al., *Health Industry Practices That Create Conflicts of Interest: A Policy Proposal for Academic Medical Centers*, 295 J. AM. MED. ASS’N. 429, 429 (2006) (“Conflicts of interest between physicians’ commitment to patient care and the desire of pharmaceutical companies and their representatives to sell their products pose challenges to the principles of medical professionalism.”); Eric G. Campbell et al., *A National Survey of Physician-Industry Relationships*, 356 NEW ENG. J. MED. 1742, 1742 (2007) (“Most physicians (94%) reported some type of relationship with the pharmaceutical industry, and most of these relationships involved receiving food in the workplace (83%) or receiving drug samples (78%). More than one third of the respondents (35%) received reimbursement for costs associated with professional meetings or continuing medical education, and more than one quarter (28%) received payment for consulting, giving lectures, or enrolling patients in trials. Cardiologists were more than twice as likely as family practitioners to receive payments. Family practitioners met more frequently with industry representatives than did physicians in other specialties, and physicians in solo, two-person, or group practices met more frequently with industry representatives than did physicians practicing in hospitals and clinics.”); Daniele Fanelli, *How Many Scientists Fabricate and Falsify Research? A Systematic Review and Meta-Analysis of Survey Data*, 4 PLOS ONE, May 2009, at 10 (“[M]isconduct in clinical, pharmacological and medical research is more widespread than in other fields. This would support growing fears that the large financial interests that often drive medical research are severely biasing it.”).

treating a variety of mental illnesses.¹⁴⁶ Despite such evidence, insurance providers continue to deny coverage of commonly utilized psychotherapies. Insurance providers will continue to ignore scientific evidence where it is cost efficient unless they are mandated to provide such treatments. Therefore, it is critical that HHS develop best practice guidelines for mental illnesses that incorporate the various empirically supported psychotherapeutic and pharmacological interventions found throughout the psychiatric and psychological literature.

First, mandating coverage for preventive and early intervention services for common and severe mental disorders is an important step in identifying mental illness. Without such preventive measures, millions of Americans will continue to hide in the shadows and remain undiagnosed. The USPSTF should identify and rate screening measures utilized to detect early signs of such disorders as schizophrenia and conduct disorder. If such measures do not warrant an “A” or “B” rating, further screening measures should be researched and developed. Detection of such conditions in childhood and adolescence will help identify those who may pose a specific safety risk to themselves or others, and who may be in need of more intensive psychotherapeutic interventions.

Next, HHS should direct the Patient-Centered Outcomes Research Institute to funnel an equal amount of its resources to understanding mental health outcomes as compared to those directed toward understanding physical health outcomes. Once PCORI establishes the efficacy of any given treatment, the HHS Secretary should incorporate the findings into best practice guidelines. All treatments incorporated into the guidelines should be defined under federal guidelines as “medically necessary.”¹⁴⁷

Mental illnesses for which multiple treatment modalities have demonstrated efficacy, and for which there are quality of life trade-offs, should be listed as disorders warranting preference-sensitive care. Decision-making aids should be utilized for patients seeking services for these identified conditions to help patients and their caregivers make informed and knowing choices about mental health care options.¹⁴⁸ Such tools already give patients suffering from disorders ranging from prostate cancer to herniated discs an opportunity to

146. See generally CLINICAL HANDBOOK OF PSYCHOLOGICAL DISORDERS, *supra* note 112 (outlining sixteen empirically validated psychotherapeutic interventions for disorders ranging from schizophrenia to eating disorders).

147. A recognized concern exists that many mental health practitioners are resistant to empirically validated treatment modalities, because they often involve “manualized” care. Gerald C. Davison, *Being Bolder With the Boulder Model: The Challenge of Education and Training in Empirically Supported Treatments*, 66 J. CONSULTING & CLINICAL PSYCHOL. 163, 163 (1998). While individual patient variables must be considered in treatment planning, mental health practitioners cannot expect insurance providers to cover treatments that are not supported by scientific evidence. Therefore, only psychotherapies that comport with research findings should mandate coverage.

148. The ACA directs HHS to develop shared decision making resource centers to “support and accelerate adoption, implementation, and effective use of patient decision aids” Patient Protection and Affordable Care Act of 2010, Pub L. No. 111-148, § 936(e)(2)(A), 124 Stat. 119, 529 (codified at 42 U.S.C. § 299b–36(e)(2)(A) (Supp. V 2012)).

evaluate the severity of their condition in relation to the side effects of a variety of proposed treatments. Patient choice that is generated from utilizing shared decision-making tools should be extended to mental health care.

If true mental health parity is to be realized under the ACA, patients need to be allowed to access quality care. The Medicaid Emergency Psychiatric Demonstration is an important first step in understanding how to better treat those in need of acute psychiatric care. The demonstration should be expanded to allow state hospital participation; such hospitals may currently be better equipped to coordinate patient aftercare within the community.

Finally, mental health care providers need to understand opportunities under the ACA to redefine their roles and integrate within comprehensive healthcare systems. By teaming with large hospital systems in overseeing patient care after discharge, mental health professionals may be able to finally enjoy stronger bargaining power in renegotiating reimbursement rates.

V. CONCLUSION

The purpose of this Note is to elucidate some of the obstacles facing consumers in accessing quality mental health care, and to expose the potential for improvements to mental health care under the ACA. If true mental health parity is to be achieved, regulators must place mental health care front and center in implementing the above-discussed provisions of the ACA. Without specific language from HHS as to what constitutes a mental disorder and which treatments for the disorder need to be covered, mental health services subject to federal parity legislation will continue to vary between states. Rules and regulations governing health care delivery systems are in rapid development. Therefore, the moment is ripe to achieve true mental health parity by incorporating mental health care services into all aspects of preventive and acute clinical care.

In implementing the EHB mental health requirement under the ACA, it is recommended that HHS immediately demand insurance coverage of all disorders listed within the recently released DSM-V, and mandate insurance coverage of both empirically validated psychotherapeutic techniques and pharmacological treatments in treating mental illnesses. If states and courts are allowed to remain divided on issues concerning what constitutes a mental illness and which treatments are medically necessary, mental illnesses will never be treated equally to physical illnesses. Additionally, mental health screening tools and patient decision-making aids must be utilized to improve the fragmented and inconsistent mental health delivery system in this country. Finally, mental health care providers need to take action to ensure fair reimbursement rates by private insurers for mental health care services. Many patients will not be able to receive needed care if mental health service providers cannot afford to take private insurance.

With mental illness affecting the lives of so many, we simply cannot bear the status quo. Identifying and treating the mentally ill is a central component to stopping the mass shooting epidemic. Without action, the “bleeding,” as

Secretary Sebelius calls it, will continue, and true mental health parity will never be achieved.