Health Insurers' Response to Current Mental Health Parity Laws

Charles Ward

I. INTRODUCTION

This Note examines how health insurance companies process claims for mental health services and stresses the importance of a functional mental healthcare model by looking to states with the most successful parity laws in order to help achieve this ambition. Since insurance regulation primarily occurs at the state level, that is where a majority of the discussion will take place. Further emphasis is placed on the parity laws in Iowa as well as states with similar mental health parity laws. The discussion then shifts to how these laws affect the conduct of health insurance companies within these states. Lastly, this Note

argues that health insurers should take a more meaningful role in complying with and promoting mental health well-being. If they fail, the consequences will be higher administrative costs, decreased access to care, and unnecessary hardship for some of the most vulnerable groups in this country.

II. BACKGROUND

Mental illness is a serious concern for millions of Americans. For children ages 3-17, 7.4 percent or approximately 4.5 million have a diagnosed behavioral problem, 7.1 percent or approximately 4.4 million have a diagnosed anxiety problem, 3.2 percent or approximately 1.9 million people are diagnosed with depression,[1] and over 9 percent or approximately 6.1 million people have some form of ADHD.[2] As for adults, nearly one in five live with some form of mental illness,[3] yet it is estimated that close to half will never receive treatment.[4] 2022 findings show that the number of adults with serious suicidal thoughts increased by an additional 664,000 people from the previous year's data.[5] The latest CDC data shows that more than 47,500 suicides took place in 2019 alone[6], while more than 70,000 drug-involved overdoses occurred that same year.[7] Additionally, the mental health problem is the worst it has ever been among historically vulnerable populations.[8] And still, these numbers may not entirely reflect the problem.[9]

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1. *Children's Mental Health*, CTRS. FOR DISEASE CONTROL & PREVENTION (June 15, 2020), https://www.cdc.gov/childrensmentalhealth/data.html [https://perma.cc/M2UM-GHHP].

2. *Id.*

3. *Statistics*, NAT'L INST. MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#:~:text=Mental%20illnesses%20are%20common%20in,mild%20to%20moderate%20to%20severe [https://perma.cc/LVD9-GV4A] (last updated Jan. 2022).

4. *See* Mary Ellen Ellis, *The Real Cost of Untreated Mental Illness in America*, CONSTELLATION BEHAV. HEALTH (Mar. 27, 2019), https://www.constellationbehavioralhealth.com/blog/the-real-cost-of-untreated-mental-illness-in-america/ [https://perma.cc/JZU8-6HNV] ("[C]lose to half of all Americans with mental illness are not getting treatment.").

5. *The State of Mental Health in America*, MENTAL HEALTH AM., https://www.mhanational.org/issues/state-mental-health-america [https://perma.cc/XZX9-Z2D9].

6. *Facts About Suicide*, CTRS. FOR DISEASE CONTROL & PREVENTION (Aug. 30, 2021), https://www.cdc.gov/suicide/facts/index.html [https://perma.cc/2SWP-ULZ7].

7. *Overdose Death Rates*, NAT'L INST. ON DRUG ABUSE (Mar. 10, 2020), https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates [https://perma.cc/J6X7-EWL9].

8. *See, e.g.*, Rachel L. Garfield, Samuel H. Zuvekas, Judith R. Lave & Julie M. Donohue, *The Impact of National Health Care Reform on Adults with Severe Mental Disorders*, AM. J. PSYCHIATRY (May 1, 2011) (finding that "individuals with severe mental disorders experience significantly higher rates of uninsurance than do those without such disorders"); Claire Pomeroy, *The U.S. Health Disadvantage: A Crisis That We Must Address Together Today*, BECKER'S HOSP. REV. (Apr. 3, 2013), https://www.beckershospitalreview.com/hospital-management-administration/the-us-health-disadvantage-a-crisis-that-we-must-address-together-today.html [https://perma.cc/UJ9Y-HMP2] ("Moreover, studies confirm that poor health outcomes in the U.S. have a disproportionate impact based on factors such as ethnicity, education, race, geography, sexual orientation, socioeconomic circumstance and immigration status.").

9. *See generally Global, Regional, and National Burden of 12 Mental Disorders in 204 Countries and Territories, 1990–2019: A Systematic Analysis for the Global Burden of Disease Study 2019*, 9 LANCET 137 (Jan. 10, 2022) (estimating the percent increase of all DALYs caused by mental and behavioral disorders from 1990–2019); *see also Disability-Adjusted Life Years (DALYs)*, (defining DALY as "the loss of the equivalent of one year of full health. DALYs for a disease or health condition are the sum of the years of life lost due to premature mortality (YLLs) and the years lived with a disability (YLDs) due to prevalent cases of the disease or health

It goes without saying that the year 2020 made a bad thing worse. Even before the COVID-19 pandemic, millions of Americans were already facing a debilitating mental health pandemic.[10] Nonetheless, COVID-19 went on to reorganize our lives in ways we never before thought possible, overrun hospital systems, and at times, shut down the global economy. At the time of writing, there have been more than 65 million confirmed COVID-19 cases and more than 850,000 deaths in this country alone.[11] Many experts who predicted the proliferation of ever-more virulent variants turned out to be prescient as Omicron swept the globe in late 2021.[12] Whatever the case might be, the undeniable result is that COVID-19 has had, and will continue to have, long-lasting negative effects that will be felt for years to come.[13]

It is against this backdrop that we must realize the complex yet vitally important role health insurance companies play in formulating better mental health outcomes for everyone. It will not be easy; no single solution can alleviate the myriad of competing interests within a healthcare system such as the United States.[14] Regardless, it is not

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condition in a population"); *see generally* Richard Layard, *A New Priority for Mental Health*, LONDON SCH. ECON. & POL. SCI. (May 2015), https://cep.lse.ac.uk/pubs/download/EA035.pdf [https://perma.cc/9MPJ-UPN4] (listing mental health as a "key determinant of life satisfaction").

10. Benedict Carey, *How Suicide Quietly Morphed Into a Public Health Crisis*, N.Y. TIMES (June 8, 2018), https://www.nytimes.com/2018/06/08/health/suicide-spade-bordain-cdc.html [https://perma.cc/45E6-Z2WA] (tracing the "steady, stubborn rise in the national suicide rate" along with the simultaneous increase in the number of Americans diagnosed with depression or anxiety in the decades preceding the pandemic).

11. *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. TIMES (Jan. 16, 2022), https://www.nytimes.com/interactive/2021/us/covid-cases.html [https://perma.cc/D4GZ-Z2AN].

12. *E.g.*, Robert Bollinger & Stuart Ray, *New Variants of Coronavirus: What You Should Know*, JOHN HOPKINS MED. (Jan. 29, 2021), https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/a-new-strain-of-coronavirus-what-you-should-know [https://perma.cc/7BMM-MSV6] (explaining how viruses mutate as well as the relationship between new variants of the COVID-19 virus—such as the Delta variant—and policy considerations like vaccines and social distancing); THE CDC, *Omicron Variant: What You Need to Know*, (Dec. 20, 2021), https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html [https://perma.cc/5E78-KWRM]; Julie Bosman, *Disruption, Dismay, Dissent: Americans Grapple with Omicron's Rise*, N.Y. TIMES (Jan. 9, 2022), https://www.nytimes.com/2022/01/09/us/united-states-covid-pandemic-omicron.html [https://perma.cc/6RPR-77JZ].

13. *See, e.g.*, Gavyn Davies, *Expect Long-Term Economic Scarring from Covid-19*, FIN. TIMES (Sept. 20, 2020), https://www.ft.com/content/3c2e524f-d1ea-4b02-9e71-e1634b316f99 [https://perma.cc/MTN9-57TL] (noting how among other economic breakdowns, "[s]tructural changes in sectoral output caused or accelerated by the pandemic will trigger bankruptcies and job losses"); Òscar Jordà, Sanjay R. Singh & Alan M. Taylor, *Longer-Run Economic Consequences of Pandemics* (Nat'l Bureau of Econ. Rsch., Working Paper No. 26934, 2020) (explaining the potential long-term effects pandemics have on the rate of real GDP per capita as lasting upwards of 40 years); Jose Maria Barrero, Nicholas Bloom & Steven J. Davis, *COVID-19 is Also a Reallocation Shock* 3 (Nat'l Bureau of Econ. Rsch., Working Paper No. 27137, 2020) (discussing job loss as a result of the pandemic); Mark É. Czeisler, Rashon I. Lane, Emiko Petrosky, Joshua F. Wiley, Aleta Christensen, Rashid Njai, Matthew D. Weaver et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1049, 1053 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf [https://perma.cc/W68Y-HYZK] ("Elevated levels of adverse mental health conditions, substance use, and suicidal ideation were reported by adults in the United States in June 2020. The prevalence of symptoms of anxiety disorder was approximately three times those reported in the second quarter of 2019 . . . and prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 . . . .").

14. When asked to spend ninety minutes explaining health care in the United States to a group of foreign healthcare executives, one commentator replied: "Ninety minutes? We probably needed a few weeks." Humphrey Taylor & Ian Morrison, *The Incredible and Wasteful Complexity of the US Healthcare System*, HEALTH CARE

hyperbolic to say health insurers have the potential to change the world, or at least the world as millions of Americans experience it.[15]

A. A Brief History of Mental Health Parity in the United States

It is harder to get mental health treatment in this country than in traditional medical or surgical procedures.[16] The reasons for this are manifold; they include people's social convictions about mental health,[17] the belief that some health care providers are not apt to handle these types of illnesses,[18] certain public policy failures, and numerous systematic conventions that vehemently protect the avaricious behavior of certain financial institutions.[19] That said, nearly all these contentions are premised on two primary concerns: cost and the inconspicuousness with which mental illness often disguises itself.[20]

BLOG (Mar. 24, 2011), https://thehealthcareblog.com/blog/2011/03/24/the-incredible-and-wasteful-complexity-of-the-us-healthcare-system/ [https://perma.cc/8XK9-CH3S].

15. *See generally* John Micklethwait & Adrian Wooldridge, *The Virus Should Wake Up the West*, BLOOMBERG (Apr. 12, 2020), https://www.bloomberg.com/opinion/articles/2020-04-13/coronavirus-pandemic-is-wake-up-call-to-reinvent-the-state (describing the capability of institutions such as insurance companies to deal with the COVID-19 pandemic as a matter of life or death).

16. *Infra* Part III.A.

17. *See* Bernice A. Pescosolido, Jack K. Martin, J. Scott Long, Tait R. Medina, Jo C. Phelan & Bruce G. Link, *"A Disease Like Any Other"? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence*, 167 AM. J. PSYCHIATRY 1321, 1322–23 (2010) (illustrating people's desire to not work closely with, socialize with, or have a person affected by mental-health illness marry into their family); Bernice A. Pescosolido, John Monahan, Bruce G. Link, Ann Stueve & Saeko Kikuzawa, *The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons with Mental Health Problems*, 89 AM. J. PUB. HEALTH 1339, 1341 (1999) (finding that participants considered people with mental health illnesses to be less competent to make financial decisions compared to simply "troubled" adults); Bernice A. Pescosolido, Danielle L. Fettes, Jack K. Martin, John Monahan & Jane D. McLeod, *Perceived Dangerousness of Children with Mental Health Problems and Support for Coerced Treatment*, 58 PSYCHIATRIC SERVS. 619, 619 (2007) (concluding that adults believe children with depression or ADHD to be significantly more dangerous than children with "daily troubles").

18. *See* Danielle F. Loeb, Elizabeth A. Bayliss, Ingrid A. Binswanger, Carey Candrian & Frank V. deGruy, *Primary Care Physician Perceptions on Caring for Complex Patients with Medical and Mental Illness*, 27 J. GEN. INTERNAL MED. 945, 945 (2012) (concluding that physician-participants "expressed concern regarding their own lack of medical knowledge, clinical experience, and communication skills in treating mental illness" and "made a compelling case for increased training in the treatment of mental illness"); Jennifer Hess Kengeter, Mental Health Attitudes and Stigma Among Medical Students: An Evaluation of the Student Mental Health Initiative 3, 14 (2017) (Ph.D. dissertation, Philadelphia College of Osteopathic Medicine) (DigitalCommons@PCOM) (finding "medical professionals have been shown to display similar stigmatizing views toward individuals with mental illnesses as held by the public" and that "quality and effectiveness of care can be compromised when physicians hold stigmatizing views"); Sarah Tulk, *The Hidden Curriculum of Mental Illness Stigma in Medical Training*, CMAJ BLOGS (Feb. 27, 2018), https://cmajblogs.com/the-hidden-curriculum-of-mental-illness-stigma-in-medical-training/ [https://perma.cc/ZR6W-XXPT] ("If they really wanted to [commit suicide] they wouldn't have come here . . . . They're just looking for attention" claimed one emergency room preceptor) (internal quotations omitted).

19. Carol Graham, *America's Crisis of Despair: A Federal Task Force for Economic Recovery and Societal Well-being*, BROOKINGS INST. (Feb. 10, 2021), https://www.brookings.edu/research/americas-crisis-of-despair-a-federal-task-force-for-economic-recovery-and-societal-well-being/ [https://perma.cc/DCH7-VCUT] (addressing the innumerable factors that contribute to the ongoing American mental health crisis).

20. For example, as an epidemiologist at Kent State University says, "It's the paradox of public health: When you do it right, nothing happens." *Yes, Social Distancing Really Works. Here's How the 1918 Flu Epidemic Proves It*, ADVISORY BD. (Mar. 26, 2020), https://www.advisory.com/en/daily-briefing/2020/03/27/social-

The good news is that people's attitude towards mental health is changing; they are fed up with the lack of fairness and are ready to reorganize what society values. Some data spearheading this change include biological research suggesting a predisposition for mental illness in some people and how mental-health-related illnesses have many of the same adverse effects on a person's life as physical illnesses.[21]

1. The Development of Federal Mental Health Parity

Mental health parity aims to require health insurance companies to provide equal coverage for both illnesses of the mind and illnesses of the body.[22] The first time a widespread initiative resembling mental health parity appeared at the national level was when President John F. Kennedy pursued mental health parity for federal employees through the Federal Employees Health Benefits Program,[23] although these efforts were short-lived. By the 1980s, any progress made up to that point was soon after undetectable.[24] President Bill Clinton later considered mental health parity during his healthcare reform efforts in 1993,[25] but these efforts were equally unsuccessful.[26]

It was only in 1996 that Senators Pete Domenici and John Danforth introduced the first round of momentous federal parity legislation known as The Mental Health Parity Act of 1996 (MHPA).[27] Although the MHPA was a compromised version of the more extensive 1992 Domenici-Wellstone bill, it nonetheless was the first of its kind and a sign of things to come.[28] According to the MHPA, insurers were prohibited from imposing disparate annual and lifetime limits for mental health benefits when compared to surgical and medical benefits as offered by a group health plan or health insurance issuer offering

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distancing [https://perma.cc/LSQ6-KYPQ].

21. *See The Relationship Between Mental Health, Mental Illness and Chronic Physical Conditions*, CANADIAN MENTAL HEALTH ASS'N (Dec. 2008), https://ontario.cmha.ca/documents/the-relationship-between-mental-health-mental-illness-and-chronic-physical-conditions/ [https://perma.cc/TQG5-6MP5] ("People living with mental illnesses experience a range of physical symptoms that result both from the illness itself and as a consequence of treatment. Mental illnesses can alter hormonal balances and sleep cycles, while many psychiatric medications have side-effects ranging from weight gain to irregular heart rhythms."); *see also Mental Health and Mental Disorders*, HEALTHYPEOPLE, https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders [https://perma.cc/VP2X-GGRQ] (last visited Jan. 29, 2022) ("Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors.").

22. *See Parity*, BLACK'S LAW DICTIONARY (11th ed. 2019) (defining "parity" as "[t]he quality, state, or condition of being equal, esp. in pay, rights, or power"); *see also* George B. Moseley III, *The U.S. Health Care Non-System, 1908-2008*, 10 AM. MED. ASS'S J. ETHICS 324, 324–31 (May 2008) (providing a detailed account of the traditional reasons for health insurance in the United States).

23. Colleen L. Barry, Haiden A. Huskamp & Howard H. Goldman, *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 408 (Sep. 2010).

24. *Id.*

25. Bernard S. Arons, Richard G. Frank, Howard H. Goldman, Thomas G. McGuire & Sharman Stephens, *Mental Health and Substance Abuse Coverage Under Health Reform*, 13 HEALTH AFFS. 192, 202 (1994).

26. *Id.*

27. *See* Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (1996) (requiring that "annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan"); *Fact Sheet: The Mental Health Parity Act*, U.S. DEP'T OF LAB. (Oct. 2008), https://web.archive.org/web/20120416004526/http://www.dol.gov/ebsa/newsroom/fsmhparity.html.

28. Health Insurance Reform Act of 1996, S. 1028, 104th Cong. § 305 (1996).

coverage in connection with a group health plan.[29] While this meant that insurers could no longer stymie access to mental health services by providing unequal coverage under a plan, the MHPA contained certain important exceptions. For example, the MHPA did not require insurance companies to cover mental health services for all plans. Rather, it only applied to group health plans that offered mental health benefits at the outset, and it did not apply to employers with fewer than 50 employees.[30] Moreover, insurers were free to charge different copays and coinsurance rates.[31] Lastly, employers could request exempt status from any requirements if they could show a one percent increase in premiums.[32]

a. The Mental Health Parity and Addiction Equity Act

To combat the vast shortcomings of the MHPA,[33] Congress eventually passed the Mental Health Parity and Addiction Equity Act in 2008 (MHPAEA).[34] This newly enacted law prohibited differences in treatment options as well as certain cost-sharing schemes insurers previously engaged in under the MHPA. For example, according to the MHPA, insurers could set daily limits on outpatient mental health services, set their own coinsurance rates (including co-pays, deductibles, and out-of-pocket maximums), and limit treatment benefits irrespective of any parity considerations.[35] Nonetheless, despite these additional requirements, the MHPAEA did not require that health insurers provide coverage for any type of mental health services.[36]

b. The Affordable Care Act

Beyond providing health care for 20 million previously uninsured Americans, the Affordable Care Act (ACA) set the stage for what would become the largest development in access to mental health services this country has ever seen.[37] Most notably, the ACA

29. *See Lifetime & Annual Limits*, U.S. DEP'T OF HEALTH & HUM. SERVS, https://www.hhs.gov/healthcare/about-the-aca/benefit-limits/index.html [https://perma.cc/YV46-ECG9] ("Previously, many plans set a lifetime limit—a dollar limit on what they would spend for your covered benefits during the entire time you were enrolled in that plan . . . [and] annual limit[s]—a dollar limit on their yearly spending for your covered benefits."); *see also Health Plans and Benefits*, U.S. DEP'T OF LAB., https://www.dol.gov/general/topic/health-plans [https://perma.cc/86E2-KVY8] (identifying different types of group health plans).

30. Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 ("[N]othing in this section shall be construed . . . as requiring a group health plan . . . to provide any mental health . . . benefits.").

31. *Infra* notes 33–36 and accompanying text.

32. *Infra* notes 33–36 and accompanying text.

33. *See* 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, 767–70 (discussing the shortcomings of the MHPA).

34. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110–343, §§ 511–12, 122 Stat. 3765, 3881–93 (codified as amended at 29 U.S.C. § 1185a).

35. The MHPAEA specifically excludes cost-sharing or coinsurance, day limits, and medical necessity requirements from its reach. Another important difference between the MHPA and the MHPAEA is that the latter also covers treatment for substance use disorders. *Id.*

36. The MHPAEA does not require large group health plans or health insurers to cover these benefits. It only stipulates that if an insurer *does* provide coverage for mental health or substance abuse disorder, then the coverage cannot be second-class to plans they offer for surgical or medical benefits. *Id.*

37. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified at 42 U.S.C. §§ 18001-18121 (2012)); *Chart Book: Accomplishments of Affordable Care Act*, CTR. ON BUDGET &

defined "mental health and substance use treatment" as an essential health benefit (EHB)[38] and required individual and small-group plans to cover all EHBs.[39] As previously noted, the MHPAEA only applied to large employers (50 or more employees) and only if they chose to provide mental health coverage. The ACA also prohibited what is known as underwriting, the process whereby insurers screen patients and, among other things, use the information to deny coverage and increase the price of cost-sharing plans. It is important to note that before the ACA, people diagnosed with conditions such as depression, anxiety, and substance use disorders were regularly labeled as having preexisting conditions.[40]

c. The 21st Century Cures Act

While not nearly as expansive as the MHPAEA or ACA, the 21st Century Cures Act, passed in 2016, demonstrates a continued interest—at least among some public officials—in increasing access to mental health services in the United States.[41] Division B of the Act includes the Helping Families in Mental Health Crisis Act, strengthening preexisting mental health parity measures.[42] The Act also sets up a $5 million grant to provide assertive community treatment for people with mental illnesses[43] and provides $1 billion to states over a two-year period to combat the opioid epidemic.[44]

2. Mental Health Parity at the State Level

Long before the MHPA was ever contemplated, states took it upon themselves to promote mental health parity by way of private insurance.[45] As early as 1970, certain states established minimum benefits for illnesses such as alcoholism, drug abuse, and specific

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POL'Y PRIORITIES (Mar. 19, 2019), https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act [https://perma.cc/9RHH-T5YH].

38. *See Health Benefits & Coverage: What Marketplace Health Insurance Plans Cover*, HEALTHCARE.GOV https://www.healthcare.gov/coverage/what-marketplace-plans-cover/ [https://perma.cc/N4WW-P2RK] (listing the ten essential health benefits under the ACA).

39. *See* Louise Norris, *How Obamacare Improved Mental Health Coverage*, HEALTH INS. & HEALTH REFORM AUTH. (Nov. 13, 2020), https://www.healthinsurance.org/obamacare/how-obamacare-improved-mental-health-coverage/ [https://perma.cc/LTA5-L2JH] ("[L]arge group plans, in general, tended to provide more generous benefits across the board; this is why the ACA's essential health benefits requirements were written to apply to the individual and small group markets.").

40. Thus, by prohibiting underwriting, the ACA also prohibited insurers from denying people coverage based on their pre-existing conditions. *See The Affordable Care Act's New Patient's Bill of Rights*, CMS.GOV (June 22, 2010), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca-new-patients-bill-of-rights [https://perma.cc/MN2U-46W4].

41. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (Dec. 13, 2016).

42. *Id.* (requiring states to use at least ten percent of any block grants they receive under the Act to provide early intervention for psychological disorders.).

43. Liz Szabo, *Landmark Mental Health Bill Sails Through U.S. Senate*, SPECTRUM NEWS (Dec. 8, 2016), https://www.spectrumnews.org/news/landmark-mental-health-bill-sails-u-s-senate/ [https://perma.cc/YQ6T-LVKB].

44. Aaron Levin, *Obama Signs Landmark Legislation with Major Mental Health Provisions*, PSYCHIATRIC NEWS (Dec. 30, 2016), https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2017.1a10 [https://perma.cc/Z75J-QQQN].

45. *See* Colleen L Barry, Haiden A. Huskamp & Howard H. Goldman, *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 MILBANK Q. 404, 408 (Sep. 2010).

mental illnesses.[46] Today, all fifty states have some form of mental health parity law;[47] and, as one would expect, these laws vary dramatically.[48]

B. The Mental-Health Parity Debate

When considering the mental health parity debate, discussions generally center on cost, quality, and access to care.[49] To better understand these arguments, a basic overview of how health insurance operates is worthwhile. First, an insurer pools together the premiums it collects from its policyholders. The cost of healthcare premiums reflects the type of coverage provided, risk factors, and the potential cost of an accident. When a policyholder needs medical care, the insurance company draws from the premiums it collects and issues payment in the form of a claim. For an insurance company, profit equals the revenue collected through premiums minus claims paid and other business expenses.[50]

Returning to the substance of the parity debate, opponents of comprehensive mental health parity laws frequently underscore how people with certain mental illnesses are at higher risk when compared to the general public. Indeed, people with certain mental illnesses—such as depression—are at a higher risk for numerous other health problems such as cardiovascular disease, diabetes, stroke, and Alzheimer's disease.[51] Opponents argue that as a result, premiums will increase for everyone to offset this phenomenon. This argument is known as adverse selection and is a prevalent topic in healthcare debates.[52]

Opponents further maintain that mandatory mental health parity will result in claims

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46. *Id.*

47. MEGAN DOUGLAS, GLENDA WREN, SAMANTHA BENT-WEBER, LAUREN TONTI, GARRY CARNEAL, TORIE KEETON, JESSICA GRILLO ET AL., EVALUATING STATE MENTAL HEALTH AND ADDICTION PARITY STATUTES: A TECHNICAL REPORT 1 (2018), https://wellbeingtrust.org/wp-content/uploads/2019/06/evaluating-state-mental-health-report-wbt-for-web.pdf [https://perma.cc/CY6K-94ST] (compiling and grading each state's parity laws).

48. *See* Aviv Shamash, *A Piecemeal, Step-by-Step Approach Toward Mental Health Parity*, 7 J. HEALTH & BIOMEDICAL L. 273, 287–92 (highlighting elements found in state parity laws that lead to more successful mental health outcomes); *infra* Part III.C.

49. Health insurance companies are usually on the frontline when it comes to opposing mental-health parity. *See* Moseley, *supra* note 22 (as far back as 1908 "commercial insurance companies" have opposed health insurance policies citing cost as the main reasons for doing so).

50. *See generally* Sonia Barkat, *How Do Health Insurance Companies Make Money?*, HEALTH CARE INSIDER (Feb. 18, 2021), https://stg.healthcareinsider.com/how-health-insurance-companies-make-money-60577 [https://perma.cc/PKK5-AV7K] (explaining "Underwriting Income" and "Investment Income").

51. *See Chronic Illness & Mental Health: Recognizing and Treating Depression*, NAT'L INST. MENTAL HEALTH, https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health [https://perma.cc/C5V7-J6WJ] (last visited Jan. 29, 2022); *compare* Faith Dickerson, Clayton H. Brown, Gail L. Daumit & Lijuan Fang, *Obesity Among Individuals with Serious Mental Illness*, 113 ACTA PSYCHIATRICA SCANDINAVICA 306 (Oct. 6, 2005) (stating that a disproportionate number of patients with mental illness are obese compared to the general population), *with The Health Effects of Overweight and Obesity*, CDC, https://www.cdc.gov/healthyweight/effects/index.html [https://perma.cc/37TS-8KXP] (stating that "[p]eople who have obesity . . . are at increased risk for many serious diseases and health conditions . . . " many of which are conditions that insurance companies are required to cover by law, such as diabetes). Prior to the Affordable Care Act, insurance companies would employ an extensive screening process to avoid adverse selection. However, this is no longer the case. *Supra* Part II.A.1.b.

52. *See, e.g.*, Evan Alexander Saltzman, Managing Adverse Selection in Health Insurance Markets: Evidence from the California and Washington ACA Exchanges (2018) (Ph.D. dissertation, University of Pennsylvania) (on file with the University of Pennsylvania Libraries).

filed by people who otherwise would not use these services.[53] This latter argument is known as moral hazard and, like adverse selection, is a popular theme throughout healthcare debates.[54] A classic example of moral hazard is when an insured person spends a "superfluous" day in the hospital or gets a procedure they otherwise would not have but for their excess coverage.[55]

Continuing with this line of reasoning, opponents maintain that the free market can usually find ways to maneuver around these requirements—i.e., some employers will forgo such plans if they become too expensive (for example, reducing the number of employees to avoid having to provide health insurance at all).[56] Opponents note this is particularly worrisome considering how close to half of the country receives health insurance through some form of an employer-sponsored plan.[57] Additionally, opponents state that some employers believe their employees would rather forgo this type of mental health coverage to receive lower premiums in return—thus infringing on the employee's right to choose what is best for themselves.[58] Lastly, opponents conclude that the unpredictability of mental health warrants any attempt at mental health parity as a financial drain and that not all social problems should be viewed through a medical lens.[59]

That said, those on the other side of the debate do not dispute the direct causal connection between an increase in coverage and an increase in cost.[60] Instead, proponents look to the obfuscated costs both society and insurers bear as a result of not providing people with adequate mental health coverage. For example, it is possible that, broadly speaking, premiums could eventually decline if high-cost future claims are abated early on.[61] Stated differently, society bears an economic cost in the form of diminished productivity.[62] And, as a last side note, while opponents focus on the ability to choose what insurance they purchase in the marketplace, they would do well to consider what choice people with mental illnesses had when first diagnosed.

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53. John A. Nyman, *Is 'Moral Hazard' Inefficient? The Policy Implications of a New Theory*, 23 HEALTH AFFS. 194, 194 (2004).

54. *Id.*

55. *But see id.* (reconsidering society's beliefs about cost and health spending as a "welfare gain, not a loss").

56. *See, e.g.*, Emily Maltby, *A Health Scare for Small Businesses*, WALL ST. J. (Jan. 16, 2013, 7:44 PM), https://www.wsj.com/articles/SB10001424127887324595704578241510527580352 [https://perma.cc/9XUJ-LKEZ] (reporting on small businesses that planned to rely more heavily on independent contractors as a way of avoiding certain ACA requirements).

57. Vaughn Himber, *How Many Americans Get Health Insurance From Their Employer?*, EHEALTH, https://www.ehealthinsurance.com/resources/small-business/how-many-americans-get-health-insurance-from-their-employer [https://perma.cc/VJP8-3YJ6].

58. Marc J. Roberts & Michael R. Reich, *Ethical Analysis in Public Health*, 359 LANCET 1055, 1056 (2002).

59. *See* Kevin Aho, *Medicalizing Mental Health: A Phenomenological Alternative*, 29 J. MED. HUMANS. 243, 244 (2008) (challenging the "bio-medical models of mental illness" that interpret certain feelings and behaviors as medical conditions treatable by some combination of drugs).

60. David McDaid, A-La Park & Kristian Wahlbeck, *The Economic Case for the Prevention of Mental Illness*, 40 ANN. REV. PUB. HEALTH 373, 373 (2019)

61. *See id.* at 383 (showing the importance of mental health services as a preventative measure).

62. *See* Jeffrey Pfeffer & Leanne Williams, *Mental Health in the Workplace: The Coming Revolution*, MCKINSEY & CO. (Dec. 8, 2020), https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/mental-health-in-the-workplace-the-coming-revolution [https://perma.cc/52SR-QY6Y] ("Even before the [pandemic], behavioral health problems were widespread, constituting a leading cause of . . . reduced productivity[] and increased health care costs.").

III. ANALYSIS

The mental health parity debate is central to one of the most partisan areas in American life—health care. After all, an essential component in implementing any federal parity legislation includes the no less contentious Affordable Care Act (which has been subject to numerous lawsuits since its inception).[63] Insurance companies are not impervious to these controversies; in fact, many of their actions contribute to the ongoing disharmony. Accordingly, the following discussion describes how insurance companies circumvent enforcement of current parity laws by, among other things, utilizing their ability to define "mental illness" and "medical necessity" and by also taking advantage of lax and bewildering enforcement policies.

A. How Insurance Companies Sidestep Existing Law

The mental health pandemic in this country did not occur overnight. Instead, only through the shortcomings of policymakers and insurance companies alike has this plight of circumstances been allowed to continue. One example is how the ACA provides seemingly negligible guidance on what constitutes a mental illness or what appropriate treatment looks like—despite listing mental illness as one of the ten required Essential Health Benefits ("EHB") provided in the Act.[64] These types of loopholes should not exist. For, what is to be said about an insurer's ability to define "mental illness" or "medical necessity" in a self-serving or superficial way?[65]

As mentioned earlier, current federal law forbids insurers from imposing financial requirements or quantitative treatment limitations on mental health; but, according to the ACA, a definition of "mental illness" or "medical necessity" provided by an insurance company is acceptable so long as it is "consistent with generally recognized independent standards of current medical practice."[66] Such definitions are usually based on certain criteria, such as peer-reviewed journals and other research-based guidelines, but these safeguards do not apply in all situations.[67] The result is a significant amount of discretion on behalf of insurance companies to define these terms.[68]

Likewise, the MHPAEA explicitly cites what are known as Non-Quantitative Treatment Limits ("NQTLs").[69] As background, an NQTL is a nonnumerical limitation on

63. *Defending the Affordable Care Act*, U.S. DEP'T JUST., https://www.justice.gov/archives/healthcare [https://perma.cc/RB65-MA9F] (showing the numerous lawsuits brought against the Affordable Care Act).

64. *Health Benefits & Coverage: What Marketplace Health Insurance Plans Cover*, *supra* note 38.

65. *See infra* Part IV.A.

66. 29 C.F.R. § 2590.712(a) (2012).

67. An additional area of debate focuses on the lack of physician participation in the "defining" process. *See* Debra Patt, *Insurance Companies Have No Place Practicing Medicine*, MORNING CONSULT (Feb. 7, 2020), https://morningconsult.com/opinions/insurance-companies-have-no-place-practicing-medicine/ (criticizing many health insurance company managers for their lack of medical knowledge).

68. Patrick J. Kennedy & Jim Ramstad, *Landmark Ruling Sets Precedent for Parity Coverage of Mental Health and Addiction Treatment*, STAT (Mar. 18, 2019), https://www.statnews.com/2019/03/18/landmark-ruling-mental-health-addiction-treatment/ [https://perma.cc/JGR9-GGGK] (criticizing the practice of insurers being the ones to define the terms by highlighting how there exists better, less biased data "available from nonprofit, clinical specialty organizations such as the American Society of Addiction Medicine").

69. *See Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*, U.S. DEP'T LAB.,

a certain type of benefit or plan. And as indicated by their name, NQTLs can be hard to detect and measure. Hence, there is evidence to suggest that these practices have taken the spot of old quantitative caps—such as limiting the number of office visits—when it comes to covered services.[70] An example of an NQTL[71] could be a "fail-first" policy, where an insurer only covers a certain treatment option after the patient has first tried, and failed, to achieve any meaningful results with an initial cheaper option.[72] As a result, insurers' can restrict coverage even if other important considerations are provided for. The specious use of NQTLs is even prevalent in states that otherwise amply define "mental illness" or "medical necessity."[73]

B. Initial Challenges Health Insurance Companies Faced

Early challenges to practices that ran afoul of the mental health parity laws at the time focused almost exclusively on whether or not an insurer's actions were "consistent with generally recognized independent standards of current medical practice" and what appropriate treatment genuinely required.[74] While these early challenges often failed to make it far in court,[75] more recent cases are starting to survive the motion to dismiss stage at a much higher rate.[76] Patrick J. Kennedy, the leading co-sponsor of the MHPAEA,

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https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf [https://perma.cc/QW5Y-4WQH] (listing examples of other nonquantitative treatment limits).

70. *Infra* notes 72–74 and accompanying text.

71. *See* April Banerjee & Steven Bruce, *Ten Years Later, Abysmal Enforcement of Mental Health Parity Laws*, FOCUS ON MENTAL DISABILITIES (People With Disabilities Found., San Francisco, C.A.), Spring-Summer 2018, http://www.pwdf.org/mental-health-parity-enforcement/ [https://perma.cc/9VFF-5W7U] ("Examples of nonquantitative treatment limitations include medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; formulary design for prescription drugs; standards for provider admission to participate in a network, including reimbursement rates; and plan methods for determining usual, customary and reasonable charges.").

72. *See* David N. Osser, *The Case Against Antidepressants for Bipolar Depression: Findings From Step-BD*, PSYCHIATRIC TIMES 29, 31 (June 16, 2020), https://www.psychiatrictimes.com/view/case-against-antidepressants-bipolar-depression-findings-step-bd ("According to a report on the Health Affairs blog, fail-first protocols, which is when plans require a patient to try a cheaper alternative to a medication first, is one of the most common types of coverage restrictions in the United States."); *see also Employer Guide for Compliance With the Mental Health Parity and Addiction Equity Act*, MILLIMAN INC., 2012, at 13, https://www.abhmass.org/images/publications/parity/millimanmentalhealthparityguidence.pdf [https://perma.cc/66LK-Y6LN] (explaining fail-first practices).

73. *See* Jill Sederstrom, *Significant Challenges Remain in Enforcing Parity Laws*, BEHAV. HEALTH EXEC. (Oct. 5, 2016), https://www.psychcongress.com/article/policy/significant-challenges-remain-enforcing-parity-laws [https://perma.cc/92TT-RFTH] ("'It's very easy to tell whether or not a plan is imposing a separate higher deductible or a separate higher cost-sharing,' Sperling says. 'It's much more subtle in the ways in which they might use aggressive prior authorization policies or medical necessity criteria to limit access to mental health treatment in a way they are not doing for medical/surgical.'").

74. 42 C.F.R. § 438.900 (2016).

75. *See* Michael C. Barnes & Stacey L. Worthy, *Achieving Real Parity: Increasing Access to Treatment for Substance Use Disorders Under the Patient Protection and Affordable Care Act and the Mental Health and Addiction Equity Act*, 36 U. ARK. LITTLE ROCK L. REV. 555, 594 (2014) ("[As of July 2014] no federal parity case appears to have made it past summary judgment, likely because when cases are dismissed on summary judgment, the matters end, and when the cases survive summary judgment, the parties typically settle.").

76. *See, e.g.*, Wit v. United Behav. Health, No. 14-CV-02346, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).

likened these developments to a "turning tide" in the area of mental health parity.[77]

Similar cases showing signs of success involve those challenging the use of NQTLs as they pertain to reimbursement policies. One such case is *Smith v. United Healthcare Insurance Company*.[78] In *Smith*, the court concluded that it was enough for a plaintiff to survive a motion to dismiss where the insurance company applied reimbursement adjustments to mental health and substance use disorder services but did not for any medical or surgical benefits.[79] The court went on to say plaintiffs need not identify a medical or surgical analog that was free from a comparable reimbursement adjustment in order for their case to proceed.[80]

C. Parity at the State Level

Looking to federal law is a worthwhile endeavor when ascertaining general trends in mental health parity legislation, but so too are states' abilities to pass and amend their own parity laws in understanding the widely disparate mental health outcomes throughout this country. This is because states have wide discretion to pass legislation that exceeds the requirements of federal parity law.[81] Mutual enrichment among states is possible by adopting the best practices from different states.

However, producing quantifiable mental health data is not always easy. That is why defining and classifying the type of parity law enforced by a certain state is generally the starting point for this type of discussion.[82] For example, Iowa's parity law is biologically based,[83] a common theme among many other states.[84] Alternatively, Illinois's parity law is based on an otherwise extensive "serious mental illness standard."[85] The least

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In this class action suit, the Court held that the insurance company breached its fiduciary duty by relying on defective medical review criteria when assessing what constitutes a medical necessity under their plan. *Id.* at *43–45, *53. *Wit* was brought by 11 plaintiffs suing United Behavioral Health on behalf of more than 50,000 individuals. *Id.* at *1–4.

77. *See* Kennedy & Ramstad, *supra* note 68 (describing the *Wit* case by saying, "the largest managed behavioral health care company in the country was found liable for protecting its bottom line at the expense of its members," and that this case illustrated that "[i]nsurers should now get the message loud and clear that there will be major consequences for discriminating against those with mental health and substance use disorders").

78. Smith v. United Healthcare Ins. Co., No. 18-CV-06336, 2019 WL 3238918 (N.D. Cal. July 18, 2019).

79. *Id.* at *5–6.

80. *Id.* at *6.

81. *See, e.g.*, CONN. INS. DEP'T, A REPORT ON MENTAL HEALTH PARITY AND COMMERCIAL HEALTH INSURANCE COMPLIANCE app. A at 2–9 (Dec. 31, 2013), https://portal.ct.gov/-/media/CID/2013CIDMentalHealthParityReportpdf.pdf [https://perma.cc/M8B8-RWXS] (comparing Connecticut's mental health parity laws with the requirements of federal parity law).

82. *See infra* Part IV (providing potential alternatives that benefit both policyholders and insurers).

83. *See* IOWA CODE ANN. § 514C.22 (2017) (clarifying the meaning of biologically based). Mental illnesses included in Iowa's statute include schizophrenia, bipolar disorders, major depressive disorders, schizo-affective disorders, obsessive-compulsive disorder, pervasive developmental disorders, and autistic disorders. *Id.* There is an ongoing debate with regards to what constitutes a biological basis. *See* Adrian Woolfson, *The Biological Basis of Mental Illness*, NATURE (Feb. 11, 2019), https://www.nature.com/articles/d41586-019-00521-2 [https://perma.cc/8869-N3YG] (discussing a study on the role of evolution in conditions such as depression and anxiety).

84. Other states with biologically based parity laws include Massachusetts, New Hampshire, New Jersey, and Ohio.

85. 215 ILL. COMP. STAT. ANN. 5/370c(a)(4) (2021):

> [C]ondition or disorder that involves a mental health condition or substance use disorder that

comprehensive laws are those that essentially mirror the MHPAEA—such as Wyoming's.[86]

D. Parity Federalism

Since federal law sets the minimum requirements that insurers must provide regarding mental health services, it is essentially the norm for insurance plans to be subject to both state and federal parity laws.[87] Unfortunately, this can result in convoluted administration and enforcement mechanisms (owning to the fact that authorities are often charged with interpreting different provisions set by federal law, state law, and even insurance companies themselves). To highlight this disharmony, it is worth mentioning that it has come to the point where some states refuse to enforce federal parity law altogether.[88]

That said, recognizing unscrupulous behavior is one thing; holding an insurer accountable is another. Until now, enforcement has regularly relied on consumers[89] and insurance companies themselves.[90] Thus, unscrupulous behavior by insurance companies has not always been easy to detect. Furthermore, even when consumers do file a complaint, that complaint's success is often spread across multiple federal agencies and dependent on the cumbersome Employee Retirement Income Security Act of 1974 (ERISA).[91]

> falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Illinois was the only state to score a perfect 100% on the Kennedy-Satcher Center for Mental Health Equity study. DOUGLAS ET AL., *supra* note 47, at 2.

86. *See* WYO. STAT. ANN. § 26-20-701 (2019) ("[S]hall meet the requirements of, and the commissioner may enforce subject to the provisions of this section, the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. § 300gg-26, as amended, and the regulations promulgated pursuant thereto as of January 1, 2018.").

87. There should be no issues where the state parity law provides greater coverage than the federal law, as the state law will be controlling. Additionally, if state law provides for less coverage, federal law will apply—although this is far less common. However, a problem occurs where federal and state courts interpret a law differently, thus leading to uneven results.

88. *See* DOUGLAS ET AL., *supra* note 47, at 5 n.4 ("Alabama, Oklahoma, Missouri, Texas and Wyoming have asserted that their state insurance commissioner lacks the authority under the current state laws to enforce the Federal Parity Law.").

89. *See* Jeremy P. Ard, *An Unfulfilled Promise: Ineffective Enforcement of Mental Health Parity*, 26 ANNS. HEALTH L. ADVANCE DIRECTIVE 70, 76–79 (2017) (listing the problems with a consumer-driven enforcement system as: (1) consumers are unaware that certain denials of mental health benefits are a violation of federal parity law ("seven percent of Americans had heard of the term 'mental health parity'"); (2) difficulty in identifying how to file an internal appeal and which state or federal agency to file a complaint with depending on their plan or coverage; and (3) consumers might be tossed between state and federal agencies as they delay or decline to process the consumer complaint); *see also* Jenny Gold, *Federal Panel Calls for Stricter Enforcement of Mental Health Care Parity Law*, NPR SHOTS (Oct. 31, 2016, 10:52 AM), http://www.npr.org/sections/health-shots/2016/10/31/500056803/federal-panel-calls-for-stricter-enforcement-of-mental-health-care-parity-law [https://perma.cc/R32Y-AZA2] (quoting Patrick J. Kennedy as saying, "[we] are asking these individuals to take up their own cases when they experience a parity violation, which usually occurs at the height of their crisis").

90. *See* Kennedy & Ramstad, *supra* note 68 (criticizing this self-reporting scheme by saying "[f]ederal and state regulators should not accept self-reports by insurers as evidence of compliance with anything").

91. Employee Retirement Income Security Act (ERISA) of 1974, Pub. L. No. 93-406, 88 Stat. 829. ERISA is the federal law regulating private employers' use of group health insurance plans. ERISA often preempts relevant state health policy, especially with regard to self-funded plans. *See generally ERISA Preemption Primer*, NAT'L ACAD. FOR STATE HEALTH POL'Y, https://www.nashp.org/wp-content/uploads/

IV. RECOMMENDATION

This Part responds to some of the techniques insurers use under current legislative schemes and provides potential alternatives that benefit both policyholders and insurers. Without meaningful change, people in this country will continue to suffer, and the possibility for more drastic, less cost-effective initiatives by state legislatures will be ever-looming in the background.

A good starting point for this type of analysis is the fifty-state survey conducted by the Kennedy-Satcher Center for Mental Health Equity that grades each state based on its current mental health parity legislation.[92] This study offers more than the chance for simple comparative analysis; instead, it serves as a tool to help "rigorous[ly] . . . measure the characteristics and prevalence of laws of interest"[93]—and will be referred to throughout the remainder of this Note.

A. Insurers' Use of the Wrong Criteria

Insurers should abandon any parochial determinations they have regarding what constitutes a medical necessity. Oftentimes, states recognize the problematic results of not providing a meaningful definition for mental illness and, thus, seek to provide a clear and concise definition. However, this is not always the case. Thus, the best practice for insurance plans would be to consistently rely on clinical experience or licensed behavioral health professionals when developing any material mental health definition, such as medical necessity, and document the factors used to support such definitions.[94] Doing so would further aid policyholders in navigating through a potential denied claim. Absent such a criterion, someone in an in-patient treatment facility may receive subnormal care to a level where they can leave the facility when, in fact, their underlying condition remains. This scenario has been criticized by the commentariat on both sides of the debate as a waste of healthcare resources.[95]

The arbitrary use of NQTLs would also decrease if insurance companies relied more heavily on clinical experience or licensed behavioral health professionals. NQTLs, now commonly in the form of medical management tools, have been criticized as a way for

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sites/default/files/ERISA_Primer.pdf [https://perma.cc/8FCF-TKMF].

92. *See* DOUGLAS ET AL., *supra* note 47, at 8 (compiling and grading the parity laws in each state).

93. Something like this is of great value in this area of study, as applying a quantitative measurement to something that is qualitative in nature is no easy task. *See id*. at 7–9.

94. Recent litigation has increasingly focused on the guideline plans used to make medical-necessity decisions regarding mental health claims. *See* Ariana v. Humana Health Plan of Tex. Inc., 854 F.3d 753 (5th Cir. 2019). For a discussion on how current rules of medical necessity can erode the effectiveness of traditional legal strategies for policing private insurers' clinical judgments in general, see Amy B. Monahan & Daniel Schwarcz, *Rules of Medical Necessity*, 107 IOWA L. REV. 423 (2022).

95. Another reason this is a best practice is that while many areas of medicine have widely recognized standards of care, mental health treatments generally do not. *See* Graison Dangor, *'Mental Health Parity' is Still an Elusive Goal in U.S. Insurance Coverage*, NPR (June 7, 2019, 5:00 AM), https://www.npr.org/sections/health-shots/2019/06/07/730404539/mental-health-parity-is-still-an-elusive-goal-in-u-s-insurance-coverage [https://perma.cc/2HDA-9W7G] ("Compared with the data on medical and surgical care . . . the data and standards to measure mental health care 'trail far behind' . . . . [In] a 2016 study of Minnesota hospitals . . . nearly one-fifth of the time patients spent in psychiatric units occurred after they were stabilized and ready to be discharged.").

insurers to limit care.[96] At their best, NQTLs can be an unnecessary transaction cost, at their worst, they are seemingly unethical. Take, for example, a scenario where an insurer has reason to believe a treatment will fail but requires it in hopes of dissuading patients from seeking additional care due to the dilatory administrative burdens. People do not want to spend copious amounts of time seeking mental health services. Such a process can seem uncomfortable in the minds of many patients who are now forced to open up to numerous individuals about their private affairs. Such is the case in corporate board rooms and other high-level professions where the topic of mental illness remains taboo.[97]

B. Administering Payments and Claims

Studies have found that even when the same in-network insurance program covers certain psychiatrists and mental health providers, these mental health providers within that in-network program are paid less than physical health providers for services billed under the same area codes.[98] Such disparities often result in these mental health providers withdrawing from the insurance companies, forcing patients to either deal with expensive out-of-network care or forgo care altogether.[99] This scenario further exacerbates the shortage of mental health practitioners throughout this country.[100] To help alleviate this problem, if a plan does not offer any reasonable access to a mental health provider, insurers should collaborate with patients and allow them to go to an alternative out-of-network

96. *See* Sederstrom, *supra* note 73 ("'It's very easy to tell whether or not a plan is imposing a separate higher deductible or a separate higher cost sharing,' Sperling says. 'It's much more subtle in the ways in which they might use aggressive prior authorization policies or medical necessity criteria to limit access to mental health treatment in a way they are not doing for medical/surgical.'").

97. There is reason to believe people want to enroll in mental health services but fear it might negatively affect their career. The type of NQTLs described above do nothing to help cure this phenomenon. *See* Brendan Murphy, *Medical Boards Must Avoid Contributing to Mental Health Stigma*, AM. MED. ASS'N (June 13, 2018), https://www.ama-assn.org/residents-students/transition-practice/medical-boards-must-avoid-contributing-mental-health-stigma [https://perma.cc/4G22-H99S] ("[When] medical boards persist in probing licensure applicants about their history of treatment for mental health instead of focusing on their current fitness to practice . . . [s]uch questions can deter physicians from accessing needed care and contribute to the stigma around mental health care."); *see also Survey of Law Student Well-Being*, ABA COMM'N ON LAW. ASSISTANCE PROGRAMS, https://www.americanbar.org/content/dam/aba/administrative/lawyer_assistance/ls_colap_law_student_survey_infograph.authcheckdam.pdf (reporting that "law students identified the character and fitness requirement as one of the top factors for not seeking mental health treatment" even though that fear is generally unfounded).

98. Stephen P. Melek, Daniel Perlman & Stoddard Davenport, MILLIMAN RSCH., ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: ANALYZING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT RATES 4 (2017), https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2017/nqtldisparityanalysis.ashx [https://perma.cc/Q2DA-AGAJ].

99. *See* Patrick J. Kennedy, *Mental Health and Addiction Care are Poorly Covered by Insurance Networks*, STAT (Dec. 10, 2019), https://www.statnews.com/2019/12/10/mental-health-addiction-care-poorly-covered-by-insurance-networks [https://perma.cc/3C5P-J9DV] ("Insurance providers do not always pay or reimburse mental health professionals the way they do physical health professionals for services rendered to clients.").

100. *See Second Analysis of Insurance Data Confirms Lack of Access to Treatment*, NAT'L ASS'N OF ADDICTION TREATMENT PROVIDERS (Dec. 21, 2017), https://www.naatp.org/resources/news/second-analysis-insurance-data-confirms-lack-access-treatment/dec-21-2017 [https://perma.cc/3EMF-EA5E] (finding that "insurers aren't living up to the letter or spirit of the parity law in two key areas: provider reimbursement rates and patient access to in-network providers" and further reporting that "behavioral health patients typically pay twice as much, or more, when they receive treatment from out-of-network psychiatrists").

provider. However, this raises the issue of being charged out-of-network prices for that provider (out-of-network care is of little use if a patient is charged out-of-network prices).[101]

Shifting to the claims aspect, if a patient's claim is denied, an insurer should furnish both the patient and the health care provider with a detailed explanation of the reasons for the denial. Doing so would increase transparency by fostering communications between patients, health care providers, and insurers. Furthermore, valuable insight regarding how insurers determine what a medically-necessary service resembles would be provided and would allow providers to give their patients more precise recommendations by quickly following a published record. Lastly, this practice could help alleviate animosity between patients and insurers, as patients would now have at least some understanding of why their claim was ultimately denied.

C. Enforcement

For meaningful mental health parity to be realized, enforcement must be both transparent and centralized.[102] State regulatory agencies will play a large role in implementing this sort of directive. Once properly established, practices such as compliance surveys and audits can help achieve these goals.[103] Among other things, compliance surveys require health insurers to review their operations and procedures to ensure that they are in accordance with state and federal parity requirements. If a compliance survey produces suspect information, audits allow insurers to remedy any non-compliance activities before they face the more expensive prospect of litigation.

D. COVID-19 and Public Policy Moving Forward

At a time when one-in-four adults have had trouble paying their bills, a third have dipped into savings or retirement accounts to make ends meet, and roughly one-in-six have had to get food from a food bank, COVID-19 has brought the issue of mental health to the forefront of American life with prodigious force.[104] The idea that we can continue to think

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101. *See generally* Dania Douglas, Sita Diehl, Ron Honberg & Angela Kimball, *Out-of-Network, Out–of–Pocket, Out–of–Options: The Unfulfilled Promise of Parity*, NAT'L ALLIANCE ON MENTAL HEALTH (2016), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf [https://perma.cc/EFQ7-MDB5] (showing the effects of out-of-network treatment options). Additionally, the inability to access these types of services does not affect all people the same. Maria Cohut, *Racism in Mental Healthcare: An Invisible Barrier* (July 3, 2020), https://www.medicalnewstoday.com/articles/racism-in-mental-healthcare-an-invisible-barrier [https://perma.cc/RX3U-5FX6].

102. Currently, enforcement is spread across numerous federal agencies and all fifty states. This diffusion of authority is but one of many concerns with respect to enforcement.

103. *See* Gold, *supra* note 89 (listing the benefits of audits in the health insurance industry); *but see* Press Release, White House, FACT SHEET: Federal Parity Task Force Takes Steps to Strengthen Insurance Coverage for Mental Health and Substance Use Disorders (Oct. 27, 2016), https://obamawhitehouse.archives.gov/the-press-office/2016/10/27/fact-sheet-mental-health-and-substance-use-disorder-parity-task-force [https://perma.cc/FZ23-MLFM] (despite their powerful regulatory use, audits are seldom used due to the limited staff and resources of the performing agencies).

104. Kim Parker, Rachel Minkin & Jesse Bennett, *Economic Fallout from COVID-19 Continues to Hit Lower-Income Americans the Hardest*, PEW RSCH. CTR. (Sep. 24, 2020), https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-

about mental health in isolation from drivers such as the economy and societal well-being is no longer defensible. We must recognize how close someone else's problems are to becoming our own and the danger this poses to society.[105]

V. CONCLUSION

Although health insurance companies are just a single part of this country's vast and complex healthcare industry, their influence is outstanding. Throughout the years, health insurance companies have increased the standard of living for millions of Americans by helping provide them with care when they need it the most. It is time we bring this impact within the purview of mental health, both for ourselves and our posterity. Doing so will result in a happier, healthier, and more productive society.

americans-the-hardest/ [https://perma.cc/UKD5-LF2B].

105. *See* Bob Bryan, *Obama Defends Obamacare: 'America is Stronger Because of the Affordable Care Act'*, BUS. INSIDER (Mar. 23, 2017), https://www.businessinsider.com/barack-obama-statement-on-obamacare-affordable-care-act-2017-3 [https://perma.cc/X5WF-UL87] ("[I]n America, health care is not a privilege for a few, but a right for everybody.").