

PAVING THE PATH TO PARITY IN HEALTH INSURANCE COVERAGE FOR MENTAL ILLNESS: NEW LAW OR MERELY GOOD INTENTIONS?

BRIAN D. SHANNON*

"[I] am losing the vague dread, the fear of the thing. And little by little I can come to look upon madness as a disease like any other."

Vincent van Gogh¹

"Although we now understand that mental illnesses are, in fact, for the most part, physical illnesses, they are still treated differently than other physical conditions. . . . Yet only 2 percent of all individuals with mental illnesses are covered by insurance which provides benefits equal to the coverage for physical illnesses."

Senator Pete Domenici²

"Any form of the mental health provision is a poison pill to the health care compromise. Mandating costly mental health benefits defeats the very purpose of health care reform which is to lower health care costs and to insure more people."

Jack Faris³

* B.S., *summa cum laude*, Angelo State University, 1979; J.D., with high honors, The University of Texas School of Law, 1982. Professor of Law, Texas Tech University School of Law. Professor Shannon also serves as the chair of the board of directors for the Lubbock (Texas) Regional Mental Health & Mental Retardation Center and as vice chair of the State Bar of Texas Committee on Disability Issues. The views set forth in this article, however, are entirely those of the author.

1. Letter from Vincent van Gogh to his brother Theo (May 1889), in 3 THE COMPLETE LETTERS OF VINCENT VAN GOGH 169 (2d ed. 2d prtng. 1981). The artist Vincent van Gogh suffered from serious mental illness and eventually committed suicide after only 10 years of painting. See E. FULLER TORREY, SURVIVING SCHIZOPHRENIA: A MANUAL FOR FAMILIES, CONSUMERS, AND PROVIDERS 124 (3d ed. 1995) (discussing van Gogh's battle with mental illness and his untimely death).

2. 142 CONG. REC. S3588-89 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici). Senator Domenici made these remarks in urging the Senate to support an amendment that would have required that insurance coverages for mental illnesses be in parity with coverages for all other illnesses. See *id.*

3. *Small Business Backs Health Care Compromise*, U.S. Newswire, June 19, 1996, available in LEXIS, News Library, US File. Faris is the president of the National Federation of Independent Business. His organization strongly opposed the enactment of the insurance parity amendment proposed in 1996. See *id.*

I. INTRODUCTION

In 1993, I began an article on the topic of insurance coverage for serious mental illness with the above statement from Vincent van Gogh.⁴ In the few short years since I wrote that article, much has transpired to validate and make known this century-old insight by the afflicted artist. Most notably, in the spring of 1996, the United States Senate approved statutory language that would have required full parity in insurance coverages for mental health services. The proffered legislation, which was jointly sponsored by Senators Domenici and Wellstone, arose as an amendment to then-pending health care reform legislation.⁵ The action by the Senate generated a substantial debate about the role of insurance with respect to mental health care, in general, as well as the treatment of serious mental illness, and the measure served to place the issue before the nation's citizens. Although Congress did not enact the expansive parity legislation as initially proposed, a substantially pared-down version ultimately emerged. Moreover, the issue has been joined, and further legislative forays are anticipated.

This article begins with an examination of the problem of inadequate insurance coverage for mental health care, with a particular focus on serious mental illness, and includes a consideration of some of the reasons for this inadequacy. The article

4. Brian D. Shannon, *The Brain Gets Sick, Too—The Case for Equal Insurance Coverage for Serious Mental Illness*, 24 ST. MARY'S L.J. 365, 366 (1993).

5. The amendment stated the following:

SEC. ____ PARITY FOR MENTAL HEALTH SERVICES.

(a) PROHIBITION.—An employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, shall not impose treatment limitations or financial requirements on the coverage of mental health services if similar limitations or requirements are not imposed on coverage for services for other conditions.

(b) RULE OF CONSTRUCTION.—Nothing in subsection (a) shall be construed as prohibiting an employee health benefit plan, or a health plan issuer offering a group health plan or an individual health plan, from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary.

Amendment No. 3681, S. 1028, 104th Cong. (1996), in 142 CONG. REC. S3670 (daily ed. Apr. 18, 1996) [hereinafter *Domenici-Wellstone Amendment*]. The Domenici-Wellstone Amendment arose as an amendment to the Health Insurance Reform Act of 1996, S. 1028, 104th Cong. (1996), a health insurance reform measure, generally referred to as the Kennedy-Kassebaum bill, that was intended to eliminate the use of pre-existing condition clauses by insurers and to make health insurance more portable.

then explores the limited efficacy of state law solutions, whether through judicial or legislative efforts, to address fully the extent of the problem. Finally, the article sets forth a consideration of current and potential federal statutory approaches to achieving parity in coverage for mental health care generally, or at least with respect to the treatment of serious mental illnesses, and includes a detailed focus on the recently failed Senate measure and the ultimate success of a narrow, compromise parity bill.

II. THE PROBLEM: INCONSISTENCIES BETWEEN KNOWLEDGE AND COVERAGE, FACT AND FICTION

An array of medical studies and analyses of the brain have established that serious mental illnesses are treatable diseases of the brain.⁶ Recent findings and research have further substantiated the neurobiological bases for serious mental illness. For example, in 1993, the *New York Times* reported that a confidential government study, entitled *Health Care Reform for Americans with Severe Mental Illnesses*, had stated that “contrary to popular myth, mental illnesses are both real and definable.”⁷ The study also declared that a “growing body of research” has revealed that mental illness can be treated successfully, and that the “division of diseases into medical and mental types becomes more arbitrary with every new study.”⁸

Indeed, indicative of the current state of knowledge regarding serious mental illnesses, the present director of the National Institute of Mental Health (“NIMH”), Dr. Stephen Hyman, is neither a psychiatrist nor a psychologist—instead, he is a molecular neuroscientist. In a 1996 statement delivered to

6. See generally Shannon, *supra* note 4, at 367-70. In this article I draw distinctions between general “mental health” concerns and serious mental illnesses such as schizophrenia, bipolar affective disorder (commonly known as manic depression), and depressive illness. Serious mental illnesses are biologically based brain diseases, whereas “mental health” concerns also include behavioral, emotional, and other coping problems. Throughout this article I will employ the terms “mental health” or “mental illness” to apply to the broader, inclusive spectrum of all mental and emotional problems and illnesses, and more narrow terms such as “serious mental illness” or “neurobiological illness” to refer to known brain diseases.

7. Robert Pear, *White House Plan Would Cover Costs of Mental Illness*, N.Y. TIMES, Mar. 16, 1993, at A1 (quoting *Health Care Reform for Americans with Severe Mental Illnesses*).

8. *Id.* Several of the report’s authors were experts from the National Institute of Mental Health.

Congress, Dr. Hyman observed that “the accumulating weight of the evidence—the great bulk of it resulting from NIMH-sponsored research—demonstrates that mental disorders are brain diseases.”⁹ Dr. Hyman then highlighted some of the agency’s recent research:

[W]e know that individuals with schizophrenia have abnormalities in the size of their cerebral ventricles, those fluid-filled cavities in the brain; simply put, in schizophrenia, we see irregularities in the ratio of brain tissue to fluid in the brain. NIMH-sponsored research also has provided compelling evidence that the connections of nerve cells in the brain, the circuits that underlie the processing of thoughts and emotions, do not develop or function normally in patients with schizophrenia [Current] scientific techniques demonstrate beyond doubt that schizophrenia is a primary brain disorder.¹⁰

Dr. Hyman reported additional research identifying the “genetic vulnerabilities of schizophrenia, manic depressive illness and other major mental disorders.”¹¹ For example, recent research on identical twins has been particularly revealing in substantiating the neurobiological roots of serious mental illnesses.¹²

Insurance plans typically provide coverage for all mental health treatment that is far more limited than that offered for physical ailments, and, despite current medical evidence regarding the biological origins of serious mental illnesses, these plans

9. *Hearing Before the Subcomm. on Labor, Health & Human Serv., Educ. & Related Agencies of the House Comm. on Appropriations*, 104th Cong. 363 (1996) [hereinafter *Hearing*] (statement of Stephen Hyman, Director, Nat’l Inst. of Mental Health, Dep’t of Health & Human Serv.).

10. *Id.* at 375. Dr. Hyman noted the dichotomy in treatment approaches from when he began his residency training in psychiatry in 1981, where the methods of treatment ranged from techniques appropriate to “patients suffering serious brain disorders” to “other situations in which the families of patients with schizophrenia, for example, were treated as if *they* were the pathogens that had caused this terrible illness.” *Id.*

11. *Id.* at 376. Dr. Hyman further observed that “an extensive body of rigorous research has demonstrated that treatment for the severe mental illnesses is both precise and cost-effective.” *Id.* at 377.

12. See E. FULLER TORREY ET AL., *SCHIZOPHRENIA AND MANIC-DEPRESSIVE DISORDER; THE BIOLOGICAL ROOTS OF MENTAL ILLNESS AS REVEALED BY THE LANDMARK STUDY OF IDENTICAL TWINS* (1994) (discussing studies of identical twins that have demonstrated a strong genetic component in these serious mental illnesses).

tend not to regard serious mental illnesses as physical in nature.¹³ As one writer has observed:

These disorders also involve the worst discrimination by insurance plans. A few decades ago, mental breakdowns were seen as freaks of personality. Since then, advances in neurosciences—the study of the nervous system—have shown that many stem from chemical imbalances in the brain. In this sense, they don't differ much from many physical diseases. So why cover them differently?¹⁴

In a similar vein, Dr. Hyman himself has questioned the current discrimination in insurance coverage that is practiced against persons with mental illness:

While I understand the importance of keeping overall health care costs within bounds, I can state without reservation that research shows no biomedical justification for differentiating serious mental illness from other serious and potentially chronic disorders of the nervous system such as stroke, brain tumor, or paralysis. There is absolutely no biomedical justification for policies that judge mental disorders as being in any way less real or less deserving of treatment¹⁵

13. See Shannon, *supra* note 4, at 370-75 (discussing differing coverages by insurance plans).

14. Robert J. Samuelson, *Hard Call on Mental Health*, WASH. POST, June 5, 1996, at A23. As support for this assertion, Samuelson quoted the former head of the National Institute of Mental Health, Dr. Frederick Goodwin: "These are brain diseases You move two inches one way in the brain, and you have [the source] of epilepsy. You move two inches the other way, you have manic depression. I treat half of my manic-depressive patients with anti-convulsants [drugs]." *Id.* (alteration in original). Dr. Goodwin has also observed that treatment success rates for certain mental illnesses are superior to those for other physical maladies:

The outcome of rigorous research is documentary proof that treatments for major mental disorders yield success rates of 60 to 80 percent. These are fully comparable to efficacy rates of treatment in many other areas of medicine and are considerably higher than rates for some widely used and accepted treatments.

Frederick K. Goodwin, *Mental Illness in Health-Care Reform*, NAT'L FORUM, Summer 1993, at 25.

15. *Hearing, supra* note 9, at 377 (statement of Dr. Stephen Hyman). See also Sue Goetinck & Tom Siegfried, *Mentally Ill Fight Disease and Stereotypes; Public Understanding Lagging Behind Scientific Research, Doctors Say*, DALLAS MORNING NEWS, Apr. 28, 1996, at A1 (asserting that "[c]ompelling scientific evidence shows that mental illness is based in biology").

What are some of the ways in which this insurance discrimination is practiced? "Most private insurers require larger co-payments and set lower reimbursement ceilings for psychiatric disorders."¹⁶ Also, in contrast to much more extensive coverage for most medical disorders, insurance policies generally restrict coverage for general mental health care, including that for serious mental illnesses, "to a limited number of days of hospitalization and a dollar ceiling on outpatient treatment."¹⁷ Indeed, during the legislative debate regarding the Domenici-Wellstone Amendment, Senator Domenici delineated the following situations commonly found in health plans:

Policies that allow 365 days in-patient care for physical illness allow only 45 days for in-patient psychiatric care. Policies that provide a lifetime cap of \$1 million for physical care have a \$50,000 cap for mental illness. Policies providing unlimited outpatient visits for physical care allow only 20 outpatient visits for mental illnesses.¹⁸

He added that "90 percent of employer-sponsored [health] plans impose such limits, despite the proven efficacy of treatments for mental illness."¹⁹

16. Erica E. Goode, *When Mental Illness Hits Home*, U.S. NEWS & WORLD REP., Apr. 24, 1989, at 55, 63. These limitations are typically present for all mental health matters and extend across a spectrum ranging from emotional, behavioral, and other coping problems to serious mental illnesses.

17. Paul S. Appelbaum, *Litigating Insurance Coverage for Mental Disorders*, 40 HOSP. & COMMUNITY PSYCHIATRY 993, 993 (1989). These restrictions on mental health coverage include:

Capping benefits at arbitrary, and often very low levels, on a per-treatment basis, an annual basis or through lifetime limits; requiring insureds to pay a high deductible, i.e., to make a major out-of-pocket investment before services are reimbursed; [and] requiring high co-payments by policyholders, e.g., limiting reimbursement to 50% of actual costs.

ANNE MARIE O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, *ADVOCATING FOR INSURANCE REFORM 13-14* (1991). Although the American Psychiatric Association has made efforts to end insurance discrimination against the mentally ill since the 1950s, the insurers' limitations on "insurance reimbursement for mental illness beyond the limitations for treatment of general medical illness—has remained the rule rather than becoming the exception." STEVEN S. SHARFSTEIN ET AL., *HEALTH INSURANCE AND PSYCHIATRIC CARE: UPDATE AND APPRAISAL 3* (1984).

18. 142 CONG. REC. S3591 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici).

19. *Id.* The senator then pointed out statistics revealing that treatment success rates for serious mental illnesses are often better than for commonly reimbursed treatments for other physical ailments, yet the insurance limitations commonly apply only to the mental illnesses. *See id.* (observing that "[t]reatment for schizophrenia has

The reasons for this disparate treatment are varied. Certainly, prejudice and stigma against persons with mental illness play a role. As former first lady Rosalynn Carter has observed, "Too few outside the mental health field understand the nature of mental disorders or how treatable they are. Not only those in medicine, but also policymakers, other health care providers, and the general public need to know more about advances in treatment."²⁰ Similarly, a medical commentator has noted, "Stigma is reflected in the attitudes of payers who view mentally ill individuals as bringing on their own anxiety states [or] depressions . . ."²¹

Insurance companies have tended to use vague clauses to provide benefits for "mental health" coverage or for "mental/nervous disorders" without further definition of what was intended to be covered by the language.²² By using terms that employ broad rubrics such as "mental health" or "mental/nervous disorders,"²³ insurers have tended to include biologically based serious mental illnesses in the exact same category as all other mental, emotional, and behavioral problems. Accordingly, the exact same policy limits and exclusions then apply across the board, regardless of the nature of the "mental" problem or illness

a 60 percent success rate; manic depression, 80 percent; major depression, 65 percent. Yet commonly reimbursed procedures such as angioplasty and arthroectomy have only a 41-percent and a 52-percent ratio . . .").

20. Rosalynn Carter, *Mental Health Policy and Health Care Reform*, NAT'L FORUM, Winter 1993, at 13, 14.

21. Steven S. Sharfstein, *Articulating the Case for Equitable Mental Health Coverage*, 42 HOSP. & COMMUNITY PSYCHIATRY 453 (1991). Dr. Sharfstein observes further that these insurance problems "are mired in continuing stigma, expectations that the public sector should care for the mentally ill, and irrational beliefs about the nature of mental illness." *Id.* Accord Steven Findlay, *The Revolution in Psychiatric Care*, U.S. NEWS & WORLD REP., Aug. 5, 1991, at 49 (observing that "insurance limitations testify to a lingering stigma" and that despite recent medical advances and discoveries, "it probably will still take years before people with mental illnesses are treated with the same degree of compassion—and insurance protection—as are victims of . . . heart disease or cancer"). As one doctor commented: "Imagine the outrage that would greet an insurance company policy to limit breast cancer treatment reimbursement to \$500. Or reimbursement for high blood pressure. Or arthritis. Is psychiatry still so cloaked in stigma that no one dares speak forcefully for it? Where is our anger?" Keith Russell Ablow, *When Money Is a Factor in Treatment; Some Tenets of For-Profit Medicine Are at Odds With Good Care*, WASH. POST, Mar. 17, 1992, at Z11.

22. For a more detailed discussion, see Shannon, *supra* note 4, at 371-75.

23. See Jeffrey Rubin, *Financing Mental Health Care*, 28 HOUS. L. REV. 143, 162 n.126 (1991) (observing that undefined terms like "mental illness" and "nervous disorders" lend themselves to ambiguity about what conditions or treatments are covered by such limitations).

involved. In turn, insurance companies have tended to reduce coverage for all "mental health" benefits in large measure because of cost concerns. Behavioral disorders, however, not neurobiological brain diseases, have accounted for the largest portion of the escalating costs.²⁴ Nonetheless, insurers have placed limits on coverage for both behavioral problems and serious mental illnesses. It is arguable that policy limits or other cost controls may be more appropriate for purely behavioral or emotional problems.²⁵ Treating serious mental illness differently from other medical conditions is difficult to justify, however.²⁶ Moreover,

24. See O'KEEFE, *supra* note 17, at 14-15. O'Keefe's research revealed the following:

The two main areas of escalating costs in the 'mental health' category are treatments for alcohol and substance abuse and the psychiatric hospitalization of adolescents. In both cases, the problems being addressed are behavioral disorders, not physical diseases. From 1986 through 1988, inpatient substance abuse and adolescent treatment were almost entirely responsible for the cost increases in mental health. During this same period, charges for inpatient psychiatric services for adults [with serious mental illnesses] *grew less rapidly* than did overall health care costs.

Id. at 15 (emphasis added).

25. As Anne O'Keefe has argued, "[P]eople who only have emotional problems can exercise choice about whether or not to seek treatment." O'KEEFE, *supra* note 17, at 15. *But cf.* Norman A. Clemens, *End Discrimination Now*, HEALTH L. NEWS, Sept. 1996, at 5, 6 (arguing that "it is specious to think that mental diseases can be divided into 'brain-based' and 'other'"). O'Keefe, however, has also observed that "people with NBD [neurobiological disorders] are subject to the same limits designed to control the overuse of discretionary mental health services by healthy people. This current state of affairs is highly discriminatory." Anne Marie O'Keefe, *Reforming Insurance Law to Provide Equitable Coverage for Persons with Neurobiological Disorders*, NEW DIRECTIONS FOR MENTAL HEALTH SERVICES, Summer 1992, at 101, 102.

26. Like sufferers of cancer, epilepsy, or Alzheimer's Disease, persons suffering from mental illnesses such as schizophrenia or bipolar affective disorder did not choose to become ill. They cannot will themselves to get better without medical care any more than persons suffering from other disabling physical diseases can. Yet, through the use of overbroad terms setting policy limits or exclusions for so-called "mental health" or "mental/nervous" benefits, insurance companies have lumped together serious mental illnesses with the purely emotional or coping problems of the "worried well." See O'KEEFE, *supra* note 17, at 15 (observing that "[f]or the seriously mentally ill, there is no choice. Treatment is not a means for personal insight or self-fulfillment. . . . Yet the mentally ill are under the same limits designed to control the utilization of discretionary mental health services."); see also Goode, *supra* note 16, at 63 (suggesting that this insurance discrimination is "just another bitter legacy of an emphasis on mental 'health' instead of mental illness, a focus that blurred distinctions between the 'worried well' and the 'walking wounded'"). For a further discussion of insurers' purported reasons for limiting coverage for mental health treatment, see Youndy C. Cook, Comment, *Messing with Our Minds: The Mental Illness Limitation in Health Insurance*, 50 U. MIAMI L. REV. 345, 346 (1996). Cf. S. Alan Savitz et al., "Parity" for Mental Health: Can It Be Achieved?, 21 ADMIN. &

requiring private insurance to cover more mental health treatment, whether one focuses on serious mental illnesses or all mental health concerns, can result in reductions in current public spending for these matters.²⁷

Despite past stigmas, of late the media has focused much more attention on the neurobiological roots of serious mental illness than in past years. Today, one often sees major newspapers or magazines that include one or more articles that attempt to correct commonly held beliefs and myths about mental illness. For example, the *Dallas Morning News* published a lengthy "page one" feature article focusing on mental illness, current research, and long-held stigma in April 1996.²⁸ Roughly contemporaneously, the *Saturday Evening Post* published two articles on manic depression.²⁹ More recently, *Newsweek* printed a column by a San Antonio, Texas, news anchor in which he openly discussed his fight with clinical depression.³⁰ These examples merely scratch

POL'Y IN MENTAL HEALTH 7 (Sept. 1993) (discussing the potential for parity and proposing a model to reduce increased utilization of unnecessary care).

27. A study by the accounting firm of Coopers & Lybrand opined that a full parity measure could reduce public sector spending on mental health "by \$16.6 billion or about 33% of current public expenditures for mental illnesses" and that the privatizing of mental health would create efficiencies that could "lower national expenditures on mental health by \$5.5 billion dollars [sic] or about 7.6% of total mental health costs." Coopers & Lybrand, *An Actuarial Analysis of the Domenici-Wellstone Amendment to S.1028 "Health Insurance Reform Act" to Provide Parity for Mental Health Benefits Under Group and Individual Insurance Plans 1* (Draft, Apr. 8, 1996) (emphasis omitted) (on file with author).

28. See Goetinck & Siegfried, *supra* note 15, at A1. After observing that jokes about physical handicaps are generally condemned, the authors gave many recent examples in which "people with mental illness are still fair game." *Id.* With regard to current understanding about mental illness, the authors stated:

Mockery, discrimination and stigma persist despite scientific research showing mental illnesses to be as real and as serious as any other sickness. Like cancer, diabetes and heart disease, mental illness can be chronic, debilitating or fatal. Even so, most health insurance plans don't offer equal coverage for mental disorders.

Id. The Dallas paper printed a follow-up article on the same theme the next day. See Tom Siegfried, *Society Defies Science's Facts on Ill Minds*, DALLAS MORNING NEWS, Apr. 29, 1996, at F8 (observing that "[m]ajor depression, manic depression, panic disorder and schizophrenia are all serious illnesses, reflections of abnormal physiology no more under personal control than breathing or heartbeat. Such diseases are chronic, often debilitating and frequently fatal.").

29. See Cory SerVaas, *The Post Investigates Manic-Depression*, SATURDAY EVENING POST, Mar.-Apr. 1996, at 46; Kay Redfield Jamison, *An Unquiet Mind*, SATURDAY EVENING POST, Mar.-Apr. 1996, at 53.

30. See Chris Marrou, *Let Me Tell You a Secret*, NEWSWEEK, June 24, 1996, at

the surface. As the news media gives more focus to the true aspects of serious mental illness, old stigmas may fade away.

III. INADEQUACIES OF STATE SOLUTIONS

Several courts have considered challenges to restrictive health insurance policies as they apply to treatment for serious mental illness. Indeed, insureds have been successful in a few of these cases. In addition, a handful of state legislatures have enacted parity legislation in the last few years. Although these case decisions and legislative enactments represent positive gains for persons with serious mental illness, they remain inadequate to address the insurance parity issue comprehensively.

A. Case Law

Several courts have sustained challenges to insurance limitations for mental health coverage that emphasized the *physical* causes or origin of the illness or condition involved.³¹ For example, in *Arkansas Blue Cross & Blue Shield, Inc. v. Doe*,³² the insured sought coverage for his daughter's hospitalization and other treatment for bipolar affective disorder.³³ Although the group policy provided broad coverage for other physical illnesses, the policy greatly limited benefits for "mental, psychiatric, or nervous conditions."³⁴ The insured sued for recovery of the full policy benefits for physical illnesses. The Arkansas Court of Appeals affirmed the trial court's holding for the insured, ruling "that the issue for its determination was whether bipolar affective disorder is a physical illness or a mental or psychiatric condition within the terms of the policy."³⁵ The court then upheld the trial court's finding that the patient's illness was a physical condition for policy purposes.³⁶

31. See Shannon, *supra* note 4, at 375-79.

32. 733 S.W.2d 429 (Ark. Ct. App. 1987) (en banc).

33. See *id.* at 431. "Bipolar affective disorder" is the more modern medical term for manic depression or manic depressive illness.

34. *Id.* at 430. Moreover, the policy did not set forth definitions of either mental or psychiatric conditions. See *id.* When the insured submitted a claim for his daughter's hospitalization and medical care, the insurer paid only those limited benefits for mental conditions. See *id.* at 431.

35. *Id.* at 432.

36. See *id.* At trial, one of the insured's experts testified that the medical research identifying bipolar affective disorder as a physical illness was overwhelming.

Similarly, in *Kunin v. Benefit Trust Life Insurance Co.*,³⁷ an insurer paid only the \$10,000 policy limit for “mental illness or nervous disorders” in reimbursement for the treatment of autism.³⁸ The Ninth Circuit determined that the term “mental illness” as used in the policy was ambiguous, at least with respect to autism.³⁹ Accordingly, the court invoked the rule of *contra proferentem* and construed the ambiguity against the insurance company.⁴⁰ Thus, the court upheld the trial court’s decision that the insurer had to pay for the treatment for autism in full—accepting the construction that autism was not a mental illness for purposes of the policy in question.⁴¹ In reaching this result, the court relied heavily on the insured’s expert testimony from psychiatrists that the term “mental illness” refers to “a behavioral disturbance with no demonstrable organic or physical basis” and that autism falls outside that definition of mental illness.⁴² Other courts have followed this approach, as well.⁴³

See id. at 431. That expert also testified that “most physicians and most people in psychiatry now classify illnesses by cause or origin.” *Id.* Although Blue Cross urged that bipolar affective disorder should be considered a mental condition because its symptoms impact a person’s mental state, the court of appeals concluded that there was credible evidence before the trier of fact that medical professionals are classifying these illnesses by their cause or origin, and not by the symptoms. *See id.* at 432. *Accord*, *Rosenthal v. Mutual Life Ins. Co.*, 732 F. Supp. 108, 110-11 (S.D. Fla. 1990) (denying insurer’s motion for summary judgment because “reasonable persons could find that Bipolar Affective Disorder is a physical illness which manifests itself through mental symptoms, such that the medical expenses incurred . . . are not limited by the limitations clause of the policy”).

37. 910 F.2d 534 (9th Cir. 1990).

38. *See id.* at 535. The insured sought to show that autism was not a “mental illness” for purposes of the policy, so that the insurance company should have paid the full amount of all medical bills. The actual medical bills for treatment of the covered child’s autism exceeded \$50,000. *See id.*

39. *See id.* at 541. The court observed that the policy contained no definitions, explanations, or illustrations of any conditions included or excluded by the term “mental illness.” *See id.*

40. *See id.* at 539. The court explained that under the rule of *contra proferentem*, a court must construe ambiguities in insurance contracts against the insurer. The court noted that the rule stems from the principle of contract construction that ambiguities “will be resolved against the drafter” of an instrument. *See id.* (quoting ALLAN D. WINDT, *INSURANCE CLAIMS & DISPUTES* § 6.02, at 281-82 (2d ed. 1988)).

41. *See id.* at 541-42.

42. *See id.* at 536.

43. *See Phillips v. Lincoln Nat’l Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992) (applying rule of *contra proferentem* and upholding summary judgment in favor of insured on grounds that organic brain syndrome fell outside the policy’s definition of mental illness); *Accord Malerbi v. Central Reserve Life of North Am. Ins. Co.*, 407

On the other hand, a number of other courts have instead accepted insurers' arguments that the manifestations or symptoms of the illness involved or the nature of the treatment provided are more critical than the origin of the problem for determining insurance coverage.⁴⁴ For example, in *Equitable Life Assurance Society v. Berry*,⁴⁵ the insured became totally disabled because of manic depression/bipolar affective disorder.⁴⁶ Like in the cases described above, the insured demonstrated that manic depression is today considered a physical illness, not a mental disorder, and that the coverage limitations for "mental/nervous" disorders in his health and disability policies should not apply to him.⁴⁷ The court in *Berry*, however, rejected focusing on the cause of the illness to determine whether the illness falls within an insurance policy's exclusion or limitation for mental health coverage.⁴⁸ Instead, the court opined that "[m]anifestation, not cause, is the yardstick" for determining whether a person's disorder is to be considered as a mental illness for purposes of an insurance policy.⁴⁹ Because the insured's experts described some of the symptoms of manic depression to include delusions and hallucinations, the court concluded that "[e]very reasonable layman would view a person manifesting such derangement as suffering from a mental disease" excluded from coverage.⁵⁰ Other courts have followed *Berry's* focus on the "ordinary layman's" understanding of mental illness in construing insurance policies

N.W.2d 157 (Neb. 1987) (upholding the trial court's finding that organic brain syndrome was not a mental illness for purposes of limited policy coverage for mental illness).

44. See Shannon, *supra* note 4, at 379-84 (detailing cases in which courts have denied claims for coverage in excess of limited "mental health" coverage); See also Cook, *supra* note 26, at 350-55 (discussing same).

45. 260 Cal. Rptr. 819 (Ct. App. 1989).

46. See *id.* at 821.

47. See *id.*

48. See *id.* at 824 n.2.

49. *Id.* at 824. But see *Phillips v. Lincoln Nat'l Life Ins. Co.*, 774 F. Supp. 495, 501 (N.D. Ill. 1991), *aff'd*, 978 F.2d 302 (7th Cir. 1992) (specifically rejecting the manifestation/symptom approach to identifying mental illnesses for purposes of insurance policy exclusions).

50. 260 Cal. Rptr. at 824. Thus, the court reasoned that the policy excluded any mental disease, regardless of the cause. See *id.* Apparently, the court believed that any illness or even physical injury that affected the brain was excluded. The court commented that "regardless of whether the disability was caused by a chemical imbalance, a blow on the head, [or] being frightened by a black cat . . . mental disorders are expressly 'not covered.' Period." *Id.*

against insureds' arguments that certain serious mental illnesses are actually medical, brain diseases.⁵¹

The problem with *Berry's* "reasonable layman" test is that the average layperson's understanding of mental illness should change with advances in medical research and greater publicity about the reality of mental illness. The court's test presumes public ignorance. Yet, as the public learns more about the actual causes and treatments for mental illness, presumably the average layperson's understanding about the meaning of the term "mental illness" will also evolve. Moreover, how far should the courts take such a standard? Would a court, for example, distinguish anemia or hypothyroidism from clinical depression even if a patient's symptoms, to a layperson, might appear identical? The *Berry* test is nonsensical.

Other courts have examined similar coverage fights by focusing primarily on the nature of the treatment involved. In *Simons v. Blue Cross & Blue Shield*,⁵² the insurer refused to pay in full for hospitalizations for the insured's treatment for anorexia nervosa, relying on the policy's limitation for psychiatric care.⁵³ The court avoided determining whether anorexia nervosa constituted a mental illness for purposes of the insurance policy, but instead reasoned that because the treatment was directed at the insured's physical malnutrition and hypotension, including nasogastric feeding and medication, it constituted medical treatment, not psychiatric care.⁵⁴ The court concluded that "[i]t is the physical condition, and the treatment required to deal with that condition, which is crucial, not the reason for the disorder."⁵⁵

51. See *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990) (construing the terms of the insurance contracts involved according to the court's view of ordinary laypersons' understanding of mental illness); accord *Stauch v. Unisys Corp.*, 24 F.3d 1054, 1056 (8th Cir. 1994) (deciding that the court should defer to laypersons' understandings).

52. 536 N.Y.S.2d 431 (App. Div. 1989).

53. See *id.* at 432.

54. See *id.* at 434-35; see also *Appelbaum*, *supra* note 17, at 993 (comparing the result in *Simons* with *Arkansas Blue Cross & Blue Shield v. Doe*, 733 S.W.2d 429 (Ark. Ct. App. 1987) (en banc), and *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990)).

55. *Simons*, 536 N.Y.S.2d at 434. Although the insured prevailed in *Simons*, that was not the case more recently in *Klebe v. Mitre Group Health Care Plan*, 894 F. Supp. 898 (D. Md. 1995), *aff'd*, No. 95-2728, 1996 U.S. App. LEXIS 17696 (4th Cir. July 19, 1996) (per curiam). In *Klebe* the court denied the insured's claim that schizophrenia should be treated as a medical condition by accepting the insurer's argument that the focus should be on the nature of the treatment. See *id.* at 905

Although challengers to policy limits on coverage for mental illness have enjoyed a few victories in the courts (and suffered a number of defeats), even the triumphs may be short-lived. In Arkansas, when the time came for renewal of policies following the decision in *Arkansas Blue Cross & Blue Shield, Inc. v. Doe*,⁵⁶ the insurer simply revised its exclusionary language to limit coverage for psychiatric illnesses "whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement."⁵⁷ Because insurance policies are creatures of contract law, insurers may simply react to adverse court decrees by amending their policies to assure the continued discrimination against persons suffering from serious mental illnesses. Accordingly, judicial challenges of discriminatory insurance coverage for severe mental illnesses may be inadequate to effect broad policy change.

*B. State Statutory Mandates: Only a Partial Solution
Given ERISA*

In the last five years, several states have enacted variations of parity legislation as attempts to change health insurance policy in their states. For example, in 1991 the Texas Legislature enacted provisions requiring parity in coverage for certain serious mental illnesses with respect to a variety of health plans applicable to government employees.⁵⁸ The statute also has required insurers to offer and make available parity coverage in private health plans.⁵⁹ More recently, other states have enacted more sweeping legislation. The states of Maine, Maryland, Minnesota,

(relying on extrinsic evidence proffered by the insurer about the nature of the treatment).

56. 733 S.W.2d 429 (Ark. Ct. App. 1987) (en banc).

57. Appelbaum, *supra* note 17, at 994.

58. See TEX. INS. CODE ANN. arts. 3.50-2, 3.50-3, 3.51-5A (West Supp. 1996) (requiring insurance coverages for serious mental illnesses at the same levels as those for other physical maladies). The statute defines "serious mental illness" to include schizophrenia, paranoid and other psychotic disorders, bipolar disorder, major depressive disorder, and schizo-affective disorder as those illnesses are "defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) III-R." See *id.* art. 3.50-2, § 3 (19), art. 3.50-3 § 3 (16), art. 3.51-14 § 1. For a detailed assessment of the legislative process associated with the enactment of the Texas parity bill, see Shannon, *supra* note 4, at 390-95.

59. See TEX. INS. CODE ANN. art. 3.51-14 (West Supp. 1996).

New Hampshire, and Rhode Island all now require parity in coverage for the treatment of mental illness.⁶⁰

Although these state mandates reach a number of persons with mental illness, they do not go far enough because of existing federal law. State legislatures have the authority to mandate coverage levels for mental illness (or other ailments) as part of their power to regulate insurance.⁶¹ Indeed, the Supreme Court has upheld the states' right to impose mandates for mental illness coverage on insurers.⁶² On the other hand, the Court has also determined that the Employee Retirement Income Security Act ("ERISA")⁶³ preempts the ability of the states to impose similar mandates on fully self-insured employee benefit plans.⁶⁴ In turn, lower courts have determined that fully self-insured health care plans do not constitute insurance and, accordingly, are not subject to state regulation.⁶⁵ Thus, state statutory mandates cannot direct coverage for many employed citizens because their employers have chosen to self-insure.⁶⁶

60. See ME. REV. STAT. ANN. tit. 24, § 2325-A (West 1996) (specifically finding that previous health coverage had discriminated against mental illness and that the costs of insuring treatment for mental illness can be reasonable); MD. ANN. CODE art. 48A, § 490V (1995); MINN. STAT. § 62Q.47 (1995); N.H. REV. STAT. ANN. § 417-E:1 (1995); R.I. GEN. LAWS § 27-38.2-1 (1995). North Dakota has also enacted a sweeping mandate that requires insurers to provide substantial benefits for the treatment of mental illness. See N.D. CENT. CODE § 26.1-36-09 (1995).

61. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

62. See *id.* at 746-47. The statute at issue in *Metropolitan Life* merely specified minimum benefits for mental health care, not equal coverage. See *id.* at 747.

63. 29 U.S.C. §§ 1001-1461 (1994).

64. See *Metropolitan Life*, 471 U.S. at 747. In *Metropolitan Life*, insurance companies asserted that ERISA preempted the states' ability to impose this type of mandated coverage on insured employee benefit plans covered by the act. See *id.* at 732. The Court rejected this argument, reasoning that ERISA reserved the states' right to regulate insurance. See *id.* at 746. The Court, however, indicated that ERISA does preempt the states' ability to impose similar mandates on uninsured (or fully self-insured) employee benefit plans because those mandates do not involve the regulation of insurance. See *id.* at 747; see generally David Gregory, *The Scope of ERISA Preemption of State Law: A Study in Effective Federalism*, 48 U. PITT. L. REV. 427, 468-70 (1987).

65. See, e.g., *Insurance Bd. of Bethlehem Steel Corp. v. Muir*, 819 F.2d 408, 412-13 (3d Cir. 1987); *Children's Hosp. v. Whitcomb*, 778 F.2d 239, 242 (5th Cir. 1985). See also *Michigan United Food & Commercial Workers Union v. Baerwaldt*, 767 F.2d 308, 312-313 (6th Cir. 1985) (refusing to find that ERISA preempted a state mandate for substance abuse coverage with respect to an employee benefit plan that was not entirely self-insured—the plan had contracted with an insurance company to pay for excess or catastrophic losses beyond the amount self-funded by the plan).

66. Of course, some employers with self-insured plans may opt to provide coverage for mental illnesses—despite the inapplicability of state mandates—either

IV. FEDERAL APPROACHES

Given both the prevalence of self-funded insurance plans, particularly among large employers, and the courts' determination that ERISA prohibits the application of state mandates to such self-funded plans, additional federal legislation is needed to assure parity in insurance coverage for severe mental illnesses. As part of its failed health care reform efforts in 1993-94, the Clinton Administration initially sought "to cover all mental illness at parity with physical illness."⁶⁷ The effort was "[s]pearheaded by Tipper Gore and her aide, Bernie Arons, formerly of the National Institute of Mental Health."⁶⁸ Indeed, President Clinton, Vice President Gore, and Mrs. Gore were among some "535,000 people who signed petitions demanding that health insurers provide the same coverage for mental illnesses as they do for physical ailments."⁶⁹ Although the various health care reform initiatives failed in 1994, coverage for mental health services was one commonly included provision. As Senator Ted Kennedy summarized more recently in the debate over the Domenici-Wellstone Amendment, "In the health insurance bill that we passed last year, we had effective equivalence between mental health and physical health, though there were some

out of a sense of moral obligation or competitive practice. See *Mental Health Benefits Growing in Use and Cost*, 163 J. ACCT., Mar. 1987, at 42; Richard G. Frank, *Regulatory Responses to Information Deficiencies in the Market for Mental Health Services*, in THE FUTURE OF MENTAL HEALTH SERVICES RESEARCH 113, 129 (Carl A. Taube et al. eds., 1989) (commenting on empirical data showing that virtually all self-insured employers have complied with state mandates). As one commentator has proffered, "ERISA has unintentionally given employers freedom from both federal and state regulations regarding what must, at minimum, be covered by employee health insurance plans." O'KEEFE, *supra* note 17, at 8.

67. Richard E. Vatz & Lee S. Weinberg, *We Should Avoid Mental Health Insurance*, USA TODAY (Magazine), Nov. 1, 1994, at 34.

68. *Id.* Tipper Gore is the wife of Vice President Al Gore. As the *New York Times* reported at the time:

Mrs. Gore said she was determined to end the "unfair and discriminatory treatment" of mental illness under private health insurance policies. Sally J. Aman, a spokeswoman for Mrs. Gore, said: "There is no good reason why a diabetic who needs insulin can get it, but someone with manic-depressive illness who needs lithium cannot [under a typical health insurance plan]."

Pear, *supra* note 7, at A16.

69. *Clinton, Gore Sign Petitions Supporting Mental Health Coverage*, AP, Mar. 30, 1993, available in LEXIS, News Library, ARCNWS File.

aspects of hospitalization that were phased in over a period of time.”⁷⁰

A. *What About the ADA?*

The Americans with Disabilities Act of 1990 (“ADA”)⁷¹ was enacted as a means of eliminating discrimination practiced against persons with disabilities.⁷² Moreover, persons with mental disabilities are included among those who are protected by the act.⁷³ Questions have arisen regarding whether the ADA may preclude employers or insurers from discriminating in the provision of insurance coverage to persons with mental illness, or whether legislation specifically addressing the discrimination issue is necessary.

Title I of the ADA bars employers from discriminating against covered individuals with respect to the “terms, conditions, and privileges of employment.”⁷⁴ This extends to “[f]ringe benefits available by virtue of employment,”⁷⁵ and employer-provided health insurance plans represent one such fringe benefit.⁷⁶ Thus, the act reaches employer-provided health insurance. On the other hand, the miscellaneous provisions set forth in Title V of the ADA relating to insurance muddy the waters.⁷⁷ Those

70. 142 CONG. REC. S3591 (daily ed. Apr. 18, 1996) (statement of Sen. Kennedy).

71. 42 U.S.C. §§ 12101-12213 (1994).

72. *See id.* § 12101(b)(1).

73. The act defines disability to include a “physical or mental impairment.” *Id.* § 12102(2)(A).

74. *Id.* § 12112(a).

75. 29 C.F.R. § 1630.4(f) (1995).

76. *See* U.S. EQUAL EMPLOYMENT OPP. COMM., *Application of the Americans with Disability [sic] Act of 1990 to Disability-Based Distinctions in Employer Provided Health Insurance* (Interim Enforcement Guidance June 1993), in DISABILITY DISCRIMINATION Tab B, 2 (1996) [hereinafter *EEOC Interim Enforcement Guidance*]. The ADA also bars employers from participating in contractual arrangements that have the effect of discriminating against persons with disabilities. *See* 42 U.S.C. § 12112(b)(2) (1994). *See also id.* § 12112(b)(1) (making it illegal for employers to limit, segregate, or classify a job applicant or employee in a way that adversely affects that person’s job opportunities or status because of a disability).

77. *See* 42 U.S.C. § 12201(c), which provides the following:

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

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

sections of the act appear to allow insurers and employers to follow underwriting and risk classification policies that are consistent with state law, provided that they are not engaging in a "subterfuge" to avoid the strictures of the ADA.⁷⁸ As Mary Giliberti, a staff attorney with the Bazelon Center for Mental Health Law, has written, "Unfortunately, this ADA section does not address the relationship between Title I's prohibiting discrimination in employee benefits and the disability-based distinctions common in many health insurance and long-term disability plans."⁷⁹ The language set forth in the statute is ambiguous, at best.⁸⁰

Although the Equal Employment Opportunity Commission ("EEOC") has recognized that the ADA applies to employer-provided health insurance plans, that agency has opined that distinctions in coverages "provided for the treatment of physical conditions on the one hand, and the benefits provided for the treatment of 'mental/nervous' conditions on the other" are *not* distinctions based on disability.⁸¹ Despite the agency's observation that restrictive coverage for "mental/nervous" conditions "may have a greater impact on certain individuals with disabilities," the EEOC concluded that "they do not intentionally discriminate on the basis of disability and do not violate the

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

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

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

78. *See id.* The insurers must show that their underwriting and risk classification efforts are "based on sound actuarial principles or [are] related to actual or reasonably anticipated experience." *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1323 (C.D. Cal. 1996) (summarizing legislative history of the insurance provisions).

79. Mary T. Giliberti, *The Application of the ADA to Distinctions Based on Mental Disability in Employer-Provided Health and Long-Term Disability Plans*, 18 MENTAL & PHYSICAL DISABILITY L. REP. 600, 600-01 (1994).

80. As Giliberti commented, "The final statement [of § 12201(c)] . . . regarding the insurance provisions' being used as a subterfuge is particularly opaque; it appears to 'trump' paragraphs 1 through 3, but does not define the key term 'subterfuge.'" *Id.* at 601.

81. EEOC *Interim Enforcement Guidance*, *supra* note 76, at Tab B, 6.

ADA.”⁸² The EEOC apparently reasoned that because “mental/nervous” clauses are broadly applicable “to the treatment of a multitude of dissimilar conditions and . . . constrain individuals both with and without disabilities” they are not distinctions based on disability.⁸³ Thus, this EEOC opinion has served to write people with serious mental illnesses (who might otherwise be protected by the ADA as to employer-provided health insurance) out from under the protections of the act—provided that the insurer or employer utilizes policy language broad enough to sweep in persons with problems that do not rise to the level of covered disabilities.

Not surprisingly, advocates for persons with mental illness have been strongly critical of this strained, curious approach by the EEOC.⁸⁴ On the other hand, the EEOC did not promulgate this *Interim Enforcement Guidance* as a rule with the force and effect of law, so it is not a statutory interpretation that is binding on the courts.⁸⁵ Nonetheless, the agency’s narrow construction of the ADA insurance provisions is both a boon for insurers and a substantial detriment to persons with serious mental illnesses who confront discriminatory insurance coverages.⁸⁶

82. *Id.* (footnotes omitted).

83. *Id.*

84. See Giliberti, *supra* note 79, at 602 (observing that the EEOC *Interim Enforcement Guidance* “permits many severe mental disabilities such as schizophrenia, multiple personality disorder, and manic depression to remain untreated and excluded, without making insurers justify denying care for those with dire needs”). Ron Honberg, legal counsel for the National Alliance for the Mentally Ill, has expressed disappointment “that the very agency charged with protecting America’s citizens from arbitrary discrimination based on race, sex and disability chose to issue guidelines which had the effect of *sanctioning* discrimination against people with severe brain disorders.” Ron Honberg, *Insurance Parity in the Courts: Status and Strategies* 5 (Apr. 13, 1996) (unpublished manuscript draft) (on file with author).

85. The Administrative Procedure Act (APA) allows agencies to promulgate binding regulations through the use of notice and comment procedures. See 5 U.S.C. § 552(a)(1)(D) (1994). The EEOC, however, did not follow such procedures in issuing this *Interim Enforcement Guidance*. Although the APA’s rulemaking procedures include exceptions for “interpretative rules” and “general statements of policy,” see *id.* § 553(b)(3)(A), such agency pronouncements are not generally binding on the courts. See *American Hosp. Ass’n v. Bowen*, 834 F.2d 1037, 1045-46 (D.C. Cir. 1987) (observing, respectively, that interpretative rules are explanatory and “do not have the full force and effect of a substantive rule” and that general statements of policy cannot set a “binding norm”).

86. It is unfortunate that the EEOC opted to reach such a narrow interpretation of the ADA’s miscellaneous insurance provisions found in 42 U.S.C. § 12201(c) (1994). Given the relative ambiguity of the ADA’s insurance exceptions (and the “subterfuge”

Rather than suing employers under Title I of the ADA, several challengers to discriminatory insurance practices have asserted claims directly against insurers or health plans under Title III of the ADA, which prohibits discrimination in places of public accommodation.⁸⁷ The act defines "public accommodation" to include insurance offices.⁸⁸ Moreover, the act bars public accommodations from denying participation to, affording unequal, lesser benefits to, or requiring separate benefits for persons with disabilities with respect to the "services, facilities, privileges, advantages, or accommodations" of the entity.⁸⁹ Thus, in several cases, individuals with disabilities have argued that an insurer has violated Title III either by denying insurance⁹⁰ or by providing unequal, lower insurance benefits for a disability.⁹¹ The courts, however, have been split with respect to whether Title III applies only to problems with physical access to public accommodations or more broadly to discrimination that ranges beyond

exception to the exceptions), it is quite likely that the courts would have been (and will be) deferential to *any* reasonable construction of the statute by the agency. *Cf.* *Chevron U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 843-844 (1984) (requiring courts to grant strong deference to reasonable agency constructions of ambiguous federal statutes).

87. *See* 42 U.S.C. §§ 12181-89 (1994). Specifically, § 12182(a) provides, "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation."

88. *See id.* § 12181(7)(F).

89. *See id.* § 12182(b)(1)(A)(i)-(iii). These prohibitions extend to benefits that the accommodation provides "directly, or through contractual, licensing, or other arrangements." *Id.*

90. *See* *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1318, 1320 (C.D. Cal. 1996) (insurer denied coverage to plaintiff whose wife was infected with HIV); *Baker v. Hartford Life Ins. Co.*, No. 94-C-4416, 1995 U.S. Dist. LEXIS 14103, at *1 (N.D. Ill. Sept. 28, 1995) (insurer denied coverage to an 11-year-old boy with a history of seizure disorder); *Pappas v. Bethesda Hosp. Ass'n*, 861 F. Supp. 616, 617 (S.D. Ohio 1994) (administrator of health plan denied family coverage to employee nurse whose husband was receiving medication for hypertension and hyperlipidemia, and whose son was a paraplegic confined to a wheelchair).

91. *See* *Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n.*, 37 F.3d 12, 14 (1st Cir. 1994) (health plan provided limited benefits for AIDS-related illnesses); *Leonard F. v. Israel Discount Bank*, No. 95-6420, 1996 U.S. App. LEXIS 14544, at *2 (2d Cir. June 13, 1996) (summary order) (insurer provided long-term disability coverage for a shorter period for persons disabled due to mental disabilities than for other physical disabilities); *Parker v. Metropolitan Life Ins. Co.*, 875 F. Supp. 1321, 1327-28 (W.D. Tenn. 1995) (insurer provided long-term disability coverage for a shorter period for persons disabled due to mental disabilities than for other physical disabilities).

physical impediments,⁹² and no clear consensus has emerged. Thus, as with Title I and its application to employers, it is uncertain whether the courts will ultimately find Title III to preclude insurers from providing discriminatory coverage for persons with serious mental illness.

B. A Specific Directive from Congress

The cure for the current obstacles at the state and federal levels to achieving parity in insurance for mental illness is fairly straightforward: Congress should enact legislation that, at the very least, specifically requires parity for serious mental illnesses. The 104th Congress attempted to pursue even broader reforms. The ill-fated Domenici-Wellstone Amendment⁹³ represented a valiant attempt to enact full parity for *all* mental health coverage. Had it been enacted, the Domenici-Wellstone Amendment would have forbidden health insurance plans from establishing or continuing "treatment limitations or financial requirements on the coverage of mental health services" that are not included for treatment or services for other physical ailments.⁹⁴ Both the mandatory nature of the proposed enactment, as well as the potential cost implications of the bill, led to a firestorm of public debate regarding the role of Congress in setting private insurance requirements for mental health benefits. The following paragraphs set forth a detailed study of the 1996 efforts in Congress to achieve parity.

At the very least, in 1996 the policy debate over the lack of adequate insurance coverage for serious mental illness was joined

92. Compare *Parker v. Metropolitan Life Ins. Co.*, 875 F. Supp. 1321, 1327-28 (W.D. Tenn. 1995) and *Pappas v. Bethesda Hosp. Ass'n.*, 861 F. Supp. 616, 619-20 (S.D. Ohio 1994) (both narrowly construing the scope of Title III as applying only to physical access to public accommodations such as insurance offices) with *Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n.*, 37 F.3d 12, 18-20 (1st Cir. 1994), *Kotev v. First Colony Life Ins. Co.*, 927 F. Supp. 1316, 1320-23 (C.D. Cal. 1996), and *Baker v. Hartford Life Ins. Co.*, No. 94-C-4416, 1995 U.S. Dist. LEXIS 14103, at *6-10 (N.D. Ill. Sept. 28, 1995) (all more broadly construing Title III to apply to more than just physical access; accordingly, these courts were willing to consider arguments that insurance offices, as places of public accommodation, cannot be discriminatory in their practices); cf. *Leonard F. v. Israel Discount Bank*, No. 95-6420, 1996 U.S. App. LEXIS 14544, at *3-6 (2d Cir. June 13, 1996) (summary order) (overturning the dismissal of insured's Title I and III claims on ripeness grounds).

93. See Domenici-Wellstone Amendment, *supra* note 5, at S3670.

94. *Id.*

in an exceptionally public manner. The public nature of the debate was in evidence from the very night that Senator Pete Domenici rose to address his and Senator Paul Wellstone's initial amendment on the Senate floor. It was well-known among senators that Senator Domenici was speaking, in part, on a personal basis. His daughter suffers from schizophrenia.⁹⁵ With respect to typical insurance coverage now offered for mental illness, Senator Domenici remarked:

[I]f you happen to be a parent of somebody who has schizophrenia, a very serious mental disease, and not some figment—it did not come because somebody's mother did not take care of them properly; it is a severe disease of the brain. If you happen to have one of those kinds of persons in your family and you have an insurance policy that is typical in America, it will, for the most part, not cover very much, it will have a cap that is very insignificant, and it will be very distinct from the rest of the policy coverage.⁹⁶

After observing that “[s]tigmas are rampant in this area,” Senator Domenici continued by indicating that the amendment had been offered as a means of addressing the discrimination practiced by insurers and health plans against individuals with mental illness.⁹⁷ The Senator emphasized: “I believe this situation represents one of the real continuing injustices in America today.”⁹⁸ Then, after a detailed discussion of some of the myths and misconceptions about serious mental illness, the Senator urged support for the amendment.⁹⁹

95. See Laura Blumenfeld, *When Politics Becomes Personal; All They Can Agree On Is the Pain of Mental Illness*, WASH. POST, June 19, 1996, at C1. The Senator sometimes has to fly home to New Mexico to provide care for his daughter. See *id.*

96. 142 CONG. REC. S3588 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici). Senator Domenici added that insurance companies “will go out of their way to cover mental illness differently and with less coverage than the basic coverage they are giving to physical ailments, diseases that we all understand.” *Id.*

97. See *id.*

98. *Id.*

99. Specifically, Senator Domenici explained:

Although we now understand that mental illnesses are, in fact, for the most part, physical illnesses, they are still treated differently than other physical conditions. The only difference between the other physical ailments and mental illness is that mental illness is a disease of the brain, and it may be more complicated, but we are making excellent strides at understanding it. Because this disease manifests itself in our centers of thought, reason, and emotion, many find it easy to deride those problems and to deride those who are afflicted, or turn their back on the problem, or

Senator Domenici was not the only member of the Senate to speak from personal experience during the debate on the Domenici-Wellstone Amendment. The amendment's co-sponsor, Senator Paul Wellstone, has an older brother who has a severe mental illness.¹⁰⁰ Indeed, at the conclusion of Senator Wellstone's comments on the Senate floor in support of the amendment, he asked to dedicate his remarks to his "brother who has struggled with mental illness almost his whole life."¹⁰¹ Senator Wellstone also discussed the history of stigma as it pertains to persons with mental illness. He observed:

For too long, mental health has been put in parenthesis; we did not want to talk about it, and we did not take it seriously as a country. The stigma of mental illness has kept many in need from seeking help, and it has prevented policymakers from providing it. And for too long, persons in need of mental health services who reach private coverage discriminatory limits have been dumped onto Government-funded programs.¹⁰²

act as if the problem does not exist. Mental illness is not due to sinful behavior. It is not due to a weakness, or frail character. These illnesses are real, and they are debilitating, and there are many who suffer from them.

Id. at S3588-89. Senator Domenici's remarks were largely directed to serious mental illnesses, although the proffered amendment applied broadly to all mental health coverage. This may be explained, in part, given that Senator Domenici's daughter suffers from a serious mental illness. Indeed, prior to the April debate, Senator Domenici's focus had been to address the more narrow question of parity for serious mental illnesses. For example, he and Senator Wellstone had previously offered a stand-alone bill, which was filed early in the first session of the 104th Congress, that would have required parity for "severe mental illnesses." *See* S. 298, 104th Cong. (1995) (defining "severe mental illness" to include "disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder"). Of the two co-sponsors, Senator Wellstone probably had a stronger interest in the more inclusive parity measure. His home state, Minnesota, had previously adopted parity legislation that applies to the broader mental health spectrum. *See* MINN. STAT. § 62Q.47 (1996).

100. *See* Blumenfeld, *supra* note 95, at C1. Indicative of the stigma and myths associated with severe mental illness, when Senator Wellstone began talking publicly about mental illness, he spoke of the experiences of "a very good friend," before later acknowledging that this "good friend" was actually his brother. *See id.*

101. 142 CONG. REC. S3590 (daily ed. Apr. 18, 1996) (statement of Sen. Wellstone). He concluded by observing that his brother "is doing great now." *Id.*

102. *Id.* at S3589.

Accordingly, the senators' amendment was intended to "require health plans to provide parity in their coverage of physical and mental health."¹⁰³

The way in which the Domenici-Wellstone Amendment arose in the Senate was a bit of a surprise. The Senators proposed the amendment as an addition to the Kennedy-Kassebaum bill, despite the objections of the sponsors. Indeed, Senator Kennedy rose to oppose the amendment, notwithstanding his apparent support for the merits of the amendment, stating that he was "strongly sympathetic."¹⁰⁴ He added, "I have difficulty in not commending, which I do, my good friends and colleagues with whom I have worked over a very considerable time on the issues of mental health. This is obviously an awkward position for me"¹⁰⁵ Senators Kennedy and Kassebaum were generally opposed to any amendments to their health care reform bill as a means of keeping the bill "clean." Accordingly, Senator Kassebaum moved to table the amendment.¹⁰⁶

Another surprising development regarding the amendment related to the degree and nature of the bipartisan support. For example, Senator Domenici is a conservative Republican who chairs the Senate Finance Committee, while Senator Wellstone has been described as being "rooted in the fringe of liberal protest

103. *Id.* According to Senator Wellstone, under the amendment, "[p]lans would be prohibited from requiring copays, or deductibles, for mental health benefits, or establishing life-time limits for mental health benefits, or establishing visit limitations for mental health services unless the same restrictions apply to other health services." *Id.*

104. *Id.* at S3591 (statement of Sen. Kennedy).

105. *Id.* (noting further that one of the first pieces of legislation in President Kennedy's administration had authorized the creation of community mental health centers). Shortly after passage of the amendment, an aide to Senator Kennedy "said the senator favors the proposal in concept, but is afraid it could weigh down the [health care reform] bill and jeopardize its passage." *Health Care: Conferees on Health Insurance Reform Will Be Appointed Soon, Aides Say*, DAILY REP. FOR EXECUTIVES, Apr. 25, 1996, available in LEXIS, News Library, DREXEC File. The bill was intended in large part to eliminate pre-existing condition requirements and make health insurance more portable.

106. See 142 CONG. REC. S3591 (daily ed. Apr. 18, 1996) (statement of Sen. Kassebaum).

politics."¹⁰⁷ But, as Senator Wellstone emphasized on the Senate floor, this is not a partisan issue:

Mental illness has touched many of our families and many of our friends. . . . Mental illness is a problem affecting all sectors of American society. It shows up in both the rural and urban areas. It affects men and women, teenagers and the elderly, every ethnic group and people in every tax bracket. It can be effectively treated just like heart disease or diabetes. Treatment not only saves lives but it also saves dollars.¹⁰⁸

Two additional senators echoed the bipartisan nature of the moving debate. First, Senator Alan Simpson, a conservative Republican from Wyoming, spoke in painful detail about his niece's tragic suicide.¹⁰⁹ Senator Simpson then urged adoption of the amendment as a way to provide a "tremendous benefit" to

107. Blumenfeld, *supra* note 95, at C1. The two senators have even joked that they probably agree on little else. *See id.* (relaying a telephone call from Wellstone to one of Domenici's aides in which Wellstone replied to a query regarding the subject of the call by stating, "Mental health—what else do we agree on? What else would it be about? Why would I even be talking to him otherwise?").

108. 142 CONG. REC. S3590 (daily ed. Apr. 18, 1996) (statement of Sen. Wellstone). In a similar vein, Senator Domenici has stressed that he is not interested in just helping his family, but to secure help for thousands of families. *See* Blumenfeld, *supra* note 95, at C1 (noting that because of his daughter, Domenici is interested in representing the interests of thousands). In contrast, having a fiscal conservative like Senator Domenici champion the mental illness parity provision placed "business advocates like Neil Trautwein. . . . [lobbyist] for the U.S. Chamber of Commerce, in an awkward position. 'It's very unlikely that we would have been on the opposite sides of an issue,' says Trautwein. 'It's kind of like the planets are out of alignment.'" *Id.*

109. Specifically, Senator Simpson relayed the following about his niece: She was a dancer; she was an artist; she was a poet; she was a guitarist; she was a singer; she was the rainbow of life.

We did not get or understand the signals in time, and the signals were very clear as we all look back now out of sheer guilt and anguish. She was tough minded, independent, loving, strong, and forceful. . . .

She began to withdraw, and then she went into some religious and almost cultish activities. . . . And after years of reaching out to us in her way and us not hearing and us not knowing, she one day decisively purchased a pistol and a few hours later purchased the ammunition and went to an isolated field, removed her shoes. . . . and blew her chest away.

That is what sometimes happens to these people, and we think, "well, but they should have tried to do something for themselves."

We thought we were doing something for her. We thought she was finally doing it for herself. She was taking medication, and it was working. But then something, something unknown, entered her mind and her life and she decided not to take the medication—knowing what would happen if she did not—and then her tragic plan of ultimate rejection came to pass.

142 CONG. REC. S3590 (daily ed. Apr. 18, 1996) (statement of Sen. Simpson).

persons with mental illness, reasoning that “there is not a soul in this Chamber that has not been grievously affected in some way by these things.”¹¹⁰ Similarly, Senator Kent Conrad, a Democrat from North Dakota, described the impact of mental illness on his former receptionist.¹¹¹ He emphasized that “[t]here are millions like her all across America,”¹¹² and that parity should be enacted because “[i]t is inescapable: An illness is an illness. There should be no differentiation between how we treat those who have a mental illness and a physical illness.”¹¹³

When the dust settled, the vote on the motion to table was a surprising thirty-three to sixty-five.¹¹⁴ Accordingly, the motion to table the amendment failed, and the amendment survived.¹¹⁵ The Senate later approved the overall Kennedy-Kassebaum health care reform bill, as amended, by a vote of 100-0. Indicative of the tone and mood of the Senate after the initial debate on the Domenici-Wellstone Amendment, another senator, Bill Bradley from New Jersey, rose to speak forcefully in favor of the proposal.¹¹⁶ He remarked:

Serious mental illness is devastating in a way that few of us can imagine. Enough of the discrimination we have shown toward those who are mentally ill. Enough of the blind eye and deaf ear we have turned toward mental health. Today, . . . I am asking that this country catch up with science, catch up

110. *Id.* Senator Simpson observed further, “It is time to minister. It is time to love and to be compassionate and time to learn so much more about these tragic things.” *Id.*

111. *See* 142 CONG. REC. S3590-91 (daily ed. Apr. 18, 1996) (statement of Sen. Conrad). He observed:

She was a beautiful and vibrant young woman. She was somebody who absolutely lit up an office. One day, she just went off the deep end with a mental illness that none of us knew that she had. Pictures were speaking to her. She had all kinds of aberrant thoughts. It led to her institutionalization. It led to her attempting to take her own life. That was a young woman, because of a suicide attempt, who did enormous damage to herself from which she will never fully recover.

Id.

112. *Id.* at S3591. He added, “As we sought to reach out and help this young woman, I . . . learned . . . that we actually treat differently those with a physical illness and those with a mental illness, and it is a tragedy.” *Id.*

113. *Id.* at S3590. He then added that in North Dakota, the state had “taken the step to recognize that there should not be discrimination between illnesses.” *Id.* at S3591.

114. *See* 142 CONG. REC. S3592 (daily ed. Apr. 18, 1996).

115. *See id.*

116. *See* 142 CONG. REC. S3738 (daily ed. Apr. 19, 1996) (statement of Sen. Bradley).

with the reality of who goes to the doctor with what kind of problem. Today, . . . we need to understand that compassion does not have to be costly. We can use our brains and show our heart and say it is time to work toward parity between mental health and physical health. We can work toward health care treatments that show that mind and body are not separate.¹¹⁷

The stunning victory for mental health advocates, however, was short-lived. Progress on the enactment of the total bill was slowed because of intense, partisan debate regarding another issue—medical savings accounts.¹¹⁸ In addition, with respect to the mental health amendment, business groups quickly began arguing that the mental health parity amendment was “vague and would drive up insurance costs.”¹¹⁹

1. The Battle over Costs

Indeed, the most vocal arguments against the Domenici-Wellstone Amendment centered on costs.¹²⁰ Advocates both for

117. *Id.* Consistent with the theme that stigma has often overshadowed scientific knowledge with respect to mental illness, the senator also observed that little doubt remains “even among the most skeptical people that biochemical disturbances are major precipitating factors for the major mental illnesses like schizophrenia, bipolar disorder, and major depression. Nonetheless, longstanding biases, which are really fears in disguise, still frame our understanding and treatment of . . . mental illness.” *Id.*

118. See Mary Jacoby, *House Passes Health Care Reform Bill; Coverage for Those Who Switch Jobs Guaranteed*, CHI. TRIB., Aug. 2, 1996, at N1 (observing that “[b]y far . . . the largest fight was over medical savings accounts, which are like Individual Retirement Accounts for health expenses . . . [that] allow people to opt out of traditional health insurance plans by making annual tax-deferred contributions to the accounts instead”). The parity amendment appeared only in the Senate version of the bill; it had not been a part of the House enactment.

119. *Health Care: Conferees on Health Insurance Reform Will Be Appointed Soon, Aides Say*, DAILY REP. FOR EXECUTIVES, Apr. 25, 1996, available in LEXIS, News Library, DREXEC File.

120. See, e.g., Samuelson, *supra* note 14, at A23 (commenting that the parity amendment “is a bad idea that would drive up health spending”); *Small Business Backs Health Care Compromise*, *supra* note 3 (quoting National Federation of Independent Business lobbyist Jack Faris’s description of the Domenici-Wellstone Amendment as “a poison pill to the health care compromise”); *Health Care: Dole Rejects Kennedy Plan on Ratio for Insurance Reform Bill Conferees*, DAILY REP. FOR EXECUTIVES, Apr. 29, 1996, available in LEXIS, News Library, DREXEC File (reporting that the Domenici-Wellstone Amendment “has drawn opposition from business and benefit groups who say the provision is too vague and would drive up premiums”). Other criticism focused on concerns about the potential for abuses by insurers and psychiatrists. See Eugene H. Methvin, *Cuckoo’s Nest*, NAT’L REV., July 15, 1996, at 38 (expressing concern about the parity amendment because of past

and against the measure have identified a variety of studies pointing differing directions about the likely costs.¹²¹ Perhaps in anticipation of likely arguments that the amendment, if enacted, would be too costly, Senator Wellstone had made the following statement on the Senate floor:

[M]ost people's instinctive reaction is to assume that this amendment would be expensive. This is not the case. As a matter of fact, in my State of Minnesota, where we have already passed legislation requiring full parity for mental health services, . . . the cost of the parity mandate was estimated to be 26 cents per member provided [per month].¹²²

The amendment's co-sponsor, Senator Domenici, also recognized that the bill would not be without costs, and observed that "[i]f it was done across the board in all policies, it would add about 1.6 percent net to the insurance coverage across the land."¹²³ Senator Conrad added that after North Dakota had ordered parity, that state's experience has been that "it does not cost more money. Oh, it does as you begin, but as you go forward, it does not cost more money, and it does not cost more money because, if you fail to treat, the physical ailments mount and become much more expensive."¹²⁴ Furthermore, Senator Wellstone stressed that

abuses by for-profit psychiatric hospitals, although acknowledging that "[r]elatively inexpensive pharmacological treatment can cure or immensely relieve" the "ravages" of obsessive-compulsive disorder, schizophrenia, clinical depression, or bipolar manic depression).

121. See *infra* notes 131-146 and accompanying text.

122. 142 CONG. REC. S3589 (daily ed. Apr. 18, 1996) (statement of Sen. Wellstone). The Minnesota cost estimate is particularly noteworthy given that Minnesota's state parity statute broadly applies to treatment for all mental health concerns. See MINN. STAT. § 62Q.47 (1996). Of course, that state mandate cannot extend to self-insured plans given ERISA. Senator Wellstone also noted that because of discrimination in insurance coverage for mental illness, "all too often people cannot work so that they can receive medical assistance. People are forced to impoverish themselves in order to qualify for the medical assistance they need [through Medicaid]." 142 CONG. REC. S3589 (daily ed. Apr. 18, 1996) (statement of Sen. Wellstone). Through the parity experience in Minnesota, persons with mental health problems have been "able to work, to live a life with dignity, and to pay their taxes." *Id.*

123. 142 CONG. REC. S3589 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici).

124. *Id.* at S3591 (statement of Sen. Conrad). Similarly, a 1993 report by an advisory council within the National Institute of Mental Health "estimated it would cost \$6.5 billion a year more to provide equal coverage for mental illnesses [nationwide], but the expenditure could reduce other health costs by \$8.7 billion

“without a doubt, mental health disorders can be diagnosed and treated in a cost-effective manner.”¹²⁵ Similarly, Senator Domenici pointed out “examples of companies that have covered with parity of treatment and, believe it or not, . . . have saved money and added to their work force in ways that are measurable and objectively beneficial.”¹²⁶

Of course, there are already costs to society and to families in the treatment of persons with serious mental illnesses, in particular, and other general mental health problems, as well. Although persons with mental problems typically lack adequate insurance, their need for mental health care, particularly among the seriously mentally ill, remains strong. If individuals with serious mental illnesses do not receive adequate mental health treatment through their health plans, they may instead be forced to obtain care from a typically overburdened public mental health system;¹²⁷ they might be in prison or jail;¹²⁸ or they might be obtaining no treatment at all.¹²⁹ Does the availability of insur-

annually.” *Clinton, Gore Sign Petitions Supporting Mental Health Coverage*, AP, Mar. 30, 1993, available in LEXIS, News Library, ARCNEWS File.

125. 142 CONG. REC. S3589 (daily ed. Apr. 18, 1996) (statement of Sen. Wellstone).

126. *Id.* at S3591 (statement of Sen. Domenici).

127. See Shannon, *supra* note 4, at 374-75 (discussing the interplay between uninsured persons with serious mental illness and the public mental health system). I am a board member for a local, public community mental health center in Texas. There are often long waiting lists for persons to receive services throughout our state. Similarly, persons who exhaust their mental health benefits under today's limited coverages might not qualify for public mental health care. Dr. Laura Lee Hall, director of research and policy for the National Alliance for the Mentally Ill, has stated: “People with serious mental illnesses can exhaust their benefits with just a few stays in the hospital. . . . If they try to turn to the public health care system, . . . they can be rejected if their income is too high.” Goetinck & Siegfried, *supra* note 15, at A1.

128. See Brian D. Shannon, *Diversion of Offenders with Mental Illness: Recent Legislative Reforms*, 59 TEX. B.J. 330, 332 (1996) (referencing a number of studies showing the large number of persons with mental illnesses in the nation's prisons and jails).

129. Many of the nation's homeless suffer from mental illness, but generally receive no treatment. See, e.g., E. Fuller Torrey, *Thirty Years of Shame: The Scandalous Neglect of the Mentally Ill Homeless*, NAT'L FORUM, Winter 1993, at 4, 4 (observing that one-third of the nation's homeless adults are seriously mentally ill); 1990 INTERAGENCY COUNCIL ON THE HOMELESS ANN. REP. 22 (reporting same); E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL (1988) (presenting various theories regarding the vast increases in population among the nation's homeless mentally ill). In addition, as part of his presentation of the amendment on the Senate floor, Senator Domenici made references to the homeless mentally ill; to the presence of many persons with mental illness in the

ance make a difference? The *American Journal of Psychiatry* has reported findings that insurance coverage is "strongly associated with care" among persons with psychiatric disorders, and that the failure "to provide insurance coverage will reduce utilization as much or more among those with a psychiatric disorder as among those without."¹³⁰ Thus, the availability of adequate coverage should lead to greater utilization of needed services.

It is undeniable that the inclusion of expanded coverage for the treatment of mental illness in the nation's health plans will cost money. The key question, however, is how much money? Alternatively, would parity truly represent an increase in health care spending, or a shifting in costs from the public sector to the private sector? Opponents of the measure have been quick to parade an array of figures indicating much higher costs for full implementation of the Domenici-Wellstone Amendment. At one extreme, a study prepared for the Association of Private Pension and Welfare Plans, a strong opponent of parity, estimated that parity just for serious mental illnesses would increase total health plan expenses between 8.4 percent and 11.4 percent.¹³¹

nation's prisons and jails due, in part, to the lack of adequate mental health care; and to the nation's insurance companies as being "part of the reason resources are not applied" to these problems. See 142 CONG. REC. S3589 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici).

130. Lawrence R. Landerman et al., *The Relationship Between Insurance Coverage and Psychiatric Disorder in Predicting Use of Mental Health Services*, 151 AM. J. PSYCHIATRY 1785, 1785 (1994) (disputing previous claims that the failure "to provide insurance coverage . . . reduce[s] discretionary but not necessary mental health care utilization"). This study focused on "outpatient mental health service utilization among those with and among those without a DSM-III psychiatric diagnosis." *Id.* Accordingly, the study examined a broader array of diagnostic categories than just serious mental illnesses. Notwithstanding the Landerman study, insurance industry officials continue to claim that increased benefits will simply result in utilization regardless of treatment efficacy. As one health care lobbyist observed, "If an employer had a \$50,000 cap versus a \$100,000 cap, they [sic] don't have any insurance that their employee would be any better off." Goetinck & Siegfried, *supra* note 15 (quoting John Kajander, the executive director of the Texas Business Group on Health, which represents employers who purchase employee health benefit plans).

131. See ACTION CENTER FOR QUALITY HEALTH CARE, ASS'N OF PRIVATE PENSION AND WELFARE PLANS, *THE COSTS OF UNIFORM PLAN PROVISIONS FOR MEDICAL & MENTAL HEALTH SERVICES: AN ANALYSIS OF S.298, THE "EQUITABLE HEALTH CARE FOR SEVERE MENTAL ILLNESS ACT"* 3 (Feb. 1996) (unpublished study) (on file with author). In contrast, the Project HOPE Center for Health Affairs reviewed various cost estimates with regard to parity for both serious mental illnesses and broader mental health coverages and observed that the Watson Wyatt Worldwide study was out of line with seven other estimates, all of which "found that premium increases would be

Furthermore, the Congressional Budget Office suggested that the parity amendment “would raise health care costs by billions of dollars” ostensibly because of increased utilization.¹³² Similarly, former Senate Majority Leader Bob Dole expressed concerns about the projected costs of the amendment shortly after Senate passage. He stated, “That’s a very, very expensive provision, and it’s going to cause all kinds of problems. I don’t see how we can keep that [parity] in the bill.”¹³³ Additionally, major newspapers focused on these cost concerns in editorials that recommended removing the amendment from the 1996 bill.¹³⁴ *The New York*

4 percent or less.” See TAMI L. MARK, PROJECT HOPE, ESTIMATES OF THE COST OF MENTAL HEALTH PARITY AND EXPANDED MENTAL HEALTH COVERAGE: A SYNTHESIS OF EXISTING ANALYSES 1 (May 10, 1996) (unpublished study) (on file with author). Even the Congressional Budget Office “assumed that the average premium increase initially would be 4 percent” for the broad parity found in the original Domenici-Wellstone Amendment. Letter from June E. O’Neill, Director, Congressional Budget Office, to Senator Nancy Kassebaum 1 (Apr. 23, 1996) (on file with author).

132. Siegfried, *supra* note 28 (remarking that the Congressional Budget Office numbers sounded “suspiciously like more prejudice” and if true, “then a solution to the nation’s health care problem is obvious — eliminate coverage for cancer and heart disease, also expensive disorders to insure”). *But see* Samuelson, *supra* note 14 (relying on the Congressional Budget Office numbers as part of an editorial opposing full adoption of the Domenici-Wellstone Amendment: “The Congressional Budget Office estimates that the requirement would raise private insurance premiums by about 4 percent in 1998, or nearly \$12 billion. Employers would respond, the CBO says, by cutting wages and other fringe benefits by almost \$11 billion and dropping insurance for about 400,000 workers.”). Even Samuelson, however, was receptive to limiting the parity provisions to *severe* mental illnesses as a “way to check spending.” *Id.* See also Lee A. Carty, *The Importance of Health Insurance Coverage for Mental Health*, HEALTH L. NEWS, Sept. 1996, at 4 (observing that “[t]here is solid documentation of the high cost to the American economy of mental health disorders: over \$130 billion a year in lost productivity, absenteeism, disability, and early death”).

133. *Health Care: Conferees on Health Insurance Reform Will Be Appointed Soon, Aides Say*, DAILY REP. FOR EXECUTIVES, Apr. 25, 1996, available in LEXIS, News Library, DREXEC File. See also *Groups Spar over Cost of Mental Health Care*, Reuters Business Report, May 31, 1996, available in LEXIS, News Library, CURNWS File (reporting a business study of the impact of the amendment conducted by Price Waterhouse, at the behest of groups such as the National Association of Manufacturers and the Business Roundtable, which “estimated that private health insurance premiums would increase by 8.7 percent . . . [and] assumed that employers would have little ability to control costs, or limit how much therapy or care someone got for a mental disorder”).

134. See, e.g., Editorial, *The Mental Health Amendment*, WASH. POST, Apr. 28, 1996, at C6 (urging that the Congress delay consideration of the parity provision despite recognizing the problems associated with current insurance limits on coverage for mental illness); Editorial, *Mr. Dole’s Health-Care Task*, N.Y. TIMES, May 30, 1996, at A26 (encouraging the Congress to “appoint a commission to come up with a cost-effective package of federally defined basic health benefits,” despite viewing the amendment as “well-meaning”). Compare, however, the comments of Linda Monk, an

Times exclaimed that the provision was “likely to boost insurance costs by as much as 10 percent and drive employers to drop coverage of 400,000 workers.”¹³⁵ The *Washington Post* took the view that there were too many unanswered questions regarding the cost impact to allow adoption after “something more than 40 minutes of sketchy floor debate on another bill.”¹³⁶

On the other hand, advocates for the Domenici-Wellstone Amendment were quick to counter the opposition’s parade of nightmarish cost stories. For example, the executive director of the National Alliance for the Mentally Ill took the *New York Times* to task for its negative editorial regarding the amendment.¹³⁷ After declaring the *Times*’ call for a commission to study insurance coverage for mental illness a “cop-out,”¹³⁸ she observed that the newspaper’s opinion that providing parity in “coverage would ‘create major economic problems’ is not supported by data.”¹³⁹ With respect to the data, the actuarial firm of Milliman & Robertson, Inc. determined that the broad parity required by the Domenici-Wellstone Amendment would raise health insurance premiums by 3.2 percent, and that parity strictly for serious mental illnesses would result in a 2.5 percent increase.¹⁴⁰ Similarly, a study performed by the Lewin Group, Inc., on behalf of the National Alliance for the Mentally Ill revealed that claims related to severe mental illnesses comprised only “between 0.43 and 1.02 percent” of the total claims submitted for all health care services included in “three large databases of

amendment as “well-meaning”). Compare, however, the comments of Linda Monk, an attorney who suffers from mental illness, who observed that the parity amendment “rescues millions of Americans like me from the back of the medical bus. But critics of the measure, among them the Business Roundtable and The [sic] Washington Post, say we should wait for another chance—just as white ministers urged Dr. Martin Luther King Jr. to be patient.” Linda R. Monk, *Mental Illness: A Right to Assisted Living; The Amendment for Mental Health Parity Eliminates a Distinction Based on Prejudice, Not Science*, DES MOINES REG., July 17, 1996, at 9.

135. *Mr. Dole’s Health-Care Task*, *supra* note 134. The editorial also opined that the amendment would cause “major economic problems.” *Id.*

136. *The Mental Health Amendment*, *supra* note 134.

137. See Laurie M. Flynn, Letter to Editor, *Insuring Mental Health Has Been Cost-Efficient*, N.Y. TIMES, June 2, 1996, § 4, at 14.

138. See *id.* Flynn noted that the matter had already been the subject of a Senate Appropriations Committee study during the healthcare reform attempts of 1993. *Id.*

139. *Id.* Flynn pointed out that “[i]n Rhode Island, Maine and New Hampshire, which have parity for severe mental illnesses, costs have risen only modestly. In states where parity laws existed, 66,000 new jobs were created in a year.” *Id.*

140. See MARK, *supra* note 131, at 4-5.

health care claims, covering the United States, between 1993 and 1995."¹⁴¹ Also, an array of advocacy groups identifying themselves as the Coalition for Fairness in Mental Health Coverage (the "Fairness Coalition")¹⁴² attacked an earlier study prepared for the Business Roundtable as "full of errors and fatally flawed."¹⁴³ Speaking on behalf of the Fairness Coalition, Dr. Melvin Sabshin of the American Psychiatric Association declared the following:

It's hardly surprising that a study bought and paid for by business groups opposed to mental illness parity would conclude that parity coverage is costly. This latest attempt by business groups to slow the drive for parity is little more than an example of the truth of the old adage about "lies, damn lies, and statistics," and it's so full of obvious flaws as to be useless to policy-makers or those interested in any serious analysis of insurance reform.¹⁴⁴

141. *New Cost Study Casts Doubt on Employer Numbers in Health Care Reform Debate; Estimated One Percent of Private Insurance Costs Result from Severe Mental Illness*, PR Newswire, May 31, 1996, available in LEXIS, News Library, US File. The study also indicated that "[s]evere mental illness related claims accounted for only 12.7 to 18.1 percent of all the behavioral health care services, which represented between 3.4 to 5.6 percent of the total health claims." *Id.* Another report identified the Lewin Group as "a reputable consulting firm" and recognized that various studies have offered "contradictory conclusions on how much it would cost to provide health insurance for mental illnesses." *Groups Spar over Cost of Mental Health*, *supra* note 133. Worth noting is that the Lewin Group study focused on the cost impact of treatment for severe mental illnesses, as opposed to all behavioral health issues. Although the National Alliance for the Mentally Ill was part of a coalition that supported the various parity initiatives, *see infra* note 142, that organization's primary focus is on serious mental illness. *See* NAT'L ALLIANCE FOR THE MENTALLY ILL, ANATOMY OF A FIGHT TO END DISCRIMINATION AGAINST PEOPLE WITH BRAIN DISORDERS 3 (Oct. 10, 1996) [hereinafter "Anatomy of a Fight"] (unpublished study) (on file with author).

142. The group is comprised of the National Alliance for the Mentally Ill, the National Mental Health Association, the American Managed Behavioral Health Association, the American Medical Association, the American Psychiatric Association, the American Psychological Association, the Federation of American Health Systems, and the National Association of Psychiatric Health Systems. *See Coalition Says Business Study of Mental Illness Parity Is "Full of Errors and Fatally Flawed,"* PR Newswire, May 31, 1996, available in LEXIS, News Library, US File (identifying membership within the coalition).

143. *Id.* For a discussion of the Business Roundtable study, *see Groups Spar over Cost of Mental Health Care*, *supra* note 133 (reporting on a Price Waterhouse study which concluded that the Domenici-Wellstone Amendment would result in an 8.7 percent increase in private health insurance premium costs).

144. *Coalition Says Business Study of Mental Illness Parity Is "Full of Errors and Fatally Flawed,"* *supra* note 142. The Coalition also noted that the earlier

Instead, the Coalition asserted that other "analyses of the likely costs of parity coverage of treatment for mental illness . . . show that the premium effects of parity would be modest (a 2.5% premium increase)" and that such a small increase "could be fully offset by a \$50 increase in the annual deductible (an increase of less than \$1 per week)."¹⁴⁵ Indeed, a Coopers & Lybrand study "found that insurance parity would save federal, state and local governments \$16.6 billion in spending for mental health."¹⁴⁶

Some of the cost concerns have stemmed from the open-ended nature of the amendatory language. The bill did not attempt to segregate serious mental illnesses from other mental health concerns. As one commentator observed, "One way to check spending would be to limit 'parity' to 'severe' mental illnesses: schizophrenia, manic depression, panic disorders, obsessive-

business study had erroneously assumed that treatment for substance abuse would be defined under the law as a mental health benefit, which substantially skewed the numbers. *See id.* Of course, opponents could accuse the psychiatry association of having as strong an interest in its viewpoint as the business interests have for their own.

145. *Id.* "[C]urrent experience in states with mental illness parity coverage laws on the books shows that there has been no dramatic cost increases related to parity." *Id.* As a group, the Fairness Coalition supported broad parity for all mental health treatment, although individual groups such as the National Alliance for the Mentally Ill wanted to give serious mental illness priority. *See Anatomy of a Fight, supra* note 141, at 3. Additionally, with regard to cost concerns, one of the amendment's staunch supporters, Senator Alan Simpson, has indicated that he "wasn't trying to break the bank, it just seemed . . . that it was fair." Blumenfeld, *supra* note 95.

146. Siegfried, *supra* note 28. This finding suggests that one result of implementation of parity legislation would be a degree of cost shifting from treatment in the public sector to private providers through insurance plans. On the other hand, given managed care initiatives, it is quite possible that successful public mental health centers might be in the marketplace as potential providers under employer health plans. The use of managed care techniques can be useful in controlling the costs of covering treatment for mental illness. That has been the experience in New Hampshire, a state with parity legislation. As stated by Stephen Merrill, New Hampshire's Republican governor:

Study after study has shown that treating severe mental illness equitably in insurance is affordable. Data shows that managed care techniques effectively control costs and provide an alternative to placing individuals on Medicaid benefits [within the public mental health system]. In the two years since I signed this [New Hampshire's mental illness treatment parity] bill . . . this has proven to be an affordable and effective piece of legislation.

Letter from New Hampshire Governor Stephen Merrill to Senators Bob Dole and Pete Domenici and House Speaker Newt Gingrich (May 28, 1996), *quoted in Coalition Says Business Study of Mental Illness Parity Is "Full of Errors and Fatally Flawed," supra* note 142.

compulsive disorders and major depressions.”¹⁴⁷ That is the approach several states have taken: requiring parity for certain serious mental *illnesses*, but not for all mental health problems.¹⁴⁸ This form of parity legislation would, at the very least, place coverage for brain illnesses with a known, neurobiological basis, on an even scale with coverage for other physical ailments and diseases.¹⁴⁹

2. Death of a Compromise

Once the vocal opposition grew with respect to the Domenici-Wellstone Amendment, the sponsors made it known that they would be willing to retreat to a less comprehensive measure. Accordingly, Senators Domenici and Wellstone announced that they would find acceptable a modest parity provision “that would prohibit insurers from setting lower annual or lifetime caps on mental health payment limits.”¹⁵⁰ In part, this move was in response to the various cost concerns. According to one estimate, had this compromise of limiting parity requirements merely to

147. Samuelson, *supra* note 14.

148. See, e.g., N.H. REV. STAT. ANN. § 417-E:1 (III) (1995) (covering mental illnesses such as schizophrenia, schizoaffective disorder, major depression, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and autism, as those illnesses are “defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association”); R.I. GEN. LAWS § 27-38.2-2(b) (1995) (covering illnesses such as schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression, obsessive compulsive disorder, or “any mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness”); TEX. INS. CODE ANN. art. 3.50-2, § 3 (19), art. 3.50-3 § 3 (16), art. 3.51-14 § 1 (West Supp. 1996) (requiring parity in coverage for such serious mental illnesses as schizophrenia, paranoid and other psychotic disorders, bipolar disorder, major depressive disorder, and schizoaffective disorder as those illnesses are “defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) III-R”).

149. Not all advocates agree with this approach, however. See Clemens, *supra* note 25, at 6 (arguing against carving out severe or biologically based mental illnesses in parity legislation by observing that “[s]uffering respects no diagnostic boundaries” and that the “brain is involved in all mental disorders”).

150. *Health Care: Compromise Set on Mental Health Parity to Ensure Provision in Final Health Bill*, DAILY REP. FOR EXECUTIVES, July 19, 1996, available in LEXIS, News Library, DREXEC File (pointing out that “[c]ompared to lifetime limits of \$1 million or more for physical illnesses, most insurance plans currently set a lifetime cap of \$50,000 for mental health treatments”).

lifetime limits and annual caps on payments been enacted, it would have reduced the estimated cost increase to 0.4 percent.¹⁵¹

Although the last-ditch reduction in the scope of the amendment was substantial, enactment of even this modest compromise would still be a major step forward.¹⁵² The problem with annual and lifetime caps is self-evident. Once the patient reaches such a cap, the coverage for the year (or lifetime) is exhausted. Of course, the mere fact that benefits are at an end does not equate to any miraculous cure. As many psychiatrists have argued, serious mental "illnesses are simply not treatable under the caps of many health plans."¹⁵³

Even the proffered compromise, however, was not enough to enable the parity amendment to be a part of the final 1996 health insurance reform bill. On August 2, 1996, the Congress completed its work on the Kennedy-Kassebaum bill, and President

151. See Letter from Laurie Flynn, Executive Director, National Alliance for the Mentally Ill, to board members and other leaders of that organization (June 14, 1996) (on file with author). The Congressional Budget Office estimated that the amendment, as pared down, would result in only "minimal" costs. See *Health Care: Compromise Set on Mental Health Parity to Ensure Provision in Final Health Bill*, *supra* note 150. Interestingly, one official from the National Alliance for the Mentally Ill has indicated that although the public battle against parity waged by business leaders focused on cost considerations, many of the opponents were more concerned about the enactment of a mandated coverage, particularly given that ERISA has previously exempted self-insured plans from state mandates. Telephone Interview with Dr. Laura Lee Hall, Deputy Director for Policy & Oversight, National Alliance for the Mentally Ill (Sept. 30, 1996).

152. As Linda Monk, an attorney and prize-winning author who suffers from mental illness, observed:

In response to cost concerns, Domenici and Wellstone have offered a compromise that would require parity of coverage for mental illness regarding lifetime caps or annual limits, but not deductibles or copayments. Even with these restrictions, the measure represents a significant advance toward equal treatment for people with biological disorders of the brain ("mental illnesses")—a condition more common than cancer, diabetes or heart disease.

Monk, *supra* note 134, at 9.

153. Goetinck & Siegfried, *supra* note 15 (also quoting Dr. John Rush of the University of Texas Southwestern Medical Branch, who stated, "There's no question that these illnesses—the more severe ones—are not treatable under a cap, any more than cancer is treatable under a cap, or heart attacks are."). The caps are simply too low to meet any repeated crisis situations. Laurie Flynn, the executive director of the National Alliance for the Mentally Ill, stated that the compromise "was needed because of the 'catastrophic' effect mental illness has on families." *Health Care: Compromise Set on Mental Health Parity to Ensure Provision in Final Health Bill*, *supra* note 150. She reportedly referred to the "drain on family resources, since most families are paying enormous sums out-of-pocket rather than seeking state or federal aid when a family member suffers from mental illness." *Id.*

Clinton indicated he would sign it;¹⁵⁴ however, House-Senate conferees eliminated the mental health parity amendment from the final bill.¹⁵⁵ A disappointed Senator Pete Domenici vowed to introduce mental health parity legislation once again and observed, "This issue is not going away."¹⁵⁶ He also exclaimed, "I want to give the 3 [million] to 5 million Americans with severe mental illness a ray of hope," and "those who think they have seen the last of this better get ready."¹⁵⁷ As of early August, however, insurance parity legislation appeared dead for 1996.

3. A New Compromise Rises from the Ashes

As Senator Domenici had indicated after the August demise of the first Domenici-Wellstone Amendment, however, he was not ready for the issue to go away. On September 5, 1996, Senators Domenici and Wellstone took steps to append a parity initiative to another pending bill. This time they introduced a parity measure as an amendment to the annual appropriations bill for the Departments of Veterans Affairs and Housing and Urban Development.¹⁵⁸ The revived parity amendment, identified as the Mental Health Parity Act of 1996,¹⁵⁹ was far narrower than the original Domenici-Wellstone Amendment. Instead, it was

154. See William E. Clayton, Jr., *A Clean Sweep for Health Bill; Senate Overwhelmingly OKs Insurance Measure*, HOUS. CHRON., Aug. 3, 1996, at A1. The final bill invalidated the use of pre-existing conditions, created a trial program for medical savings accounts, increased the deductibility of health insurance expenses for the self-employed, and created new health-care fraud provisions. See *id.*

155. See *id.*

156. Eric Schmitt, *Wages and Health Lead the Agenda as Congress Acts*, N.Y. TIMES, Aug. 3, 1996, § 1, at 1.

157. Lee Bowman, *Senate OK Sends Health Care Bill to White House*, CLEVELAND PLAIN DEALER, Aug. 3, 1996, at 10A. Senator Domenici reportedly added that "[i]t is common . . . for companies to limit coverage for mental health to \$50,000 in a lifetime, compared with \$1 million for physical diseases. 'If that's not discrimination, I've never seen it,' he said." Helen Dewar & Judith Havemann, *Water, Wage Bills Pass as Congress Recesses; Medical Coverage Portability Included in Final Flurry*, WASH. POST, Aug. 3, 1996, at A1. After the conferees excised the parity amendment, "an angry Domenici took to the Senate floor . . . to castigate his colleagues" and he declared, "There is a total lack of willingness to understand the nature of this problem, which is a blight on America, a blight on our insurance companies, and a blight on our business community that continues to resist moving in the direction of parity." *Clinton Says He Will Sign Compromise Health Bill*, NAT'L J.'S CONGRESS DAILY, Aug. 1, 1996, available in LEXIS, News Library, CNGDLY File.

158. See 142 CONG. REC. S9915-16 (daily ed. Sept. 5, 1996) (an amendment to H.R. 3666, 104th Cong.).

159. *Id.* at S9916.

essentially a reintroduction of the earlier last-ditch compromise measure to require parity for annual caps and lifetime limits on mental health benefits.¹⁶⁰ On the other hand, it did apply to such caps and limits for all mental health treatment—ranging from serious mental illnesses to behavioral, emotional, and other coping problems.

This time the more limited parity provision, the Mental Health Parity Act of 1996, proved successful. The Senate adopted a version of the bill by the vote of 82-15 on September 5, 1996.¹⁶¹ As passed by the Senate, the scaled-down parity measure purported to require health insurers to treat benefits for mental health treatment the same as for other medical benefits with respect to annual limits and lifetime caps, but the bill did not apply to employers with fewer than twenty-six employees.¹⁶² Once more, the senators debated cost concerns as part of their deliberations. Senator Kent Conrad, in again offering his support for a parity measure, emphasized that according to the Congressional Budget Office, this scaled-back parity measure “would increase health insurance premiums by .16 percent.”¹⁶³ Based in part on this estimate, Senator Phil Gramm offered an amendment that would exempt any employer if the parity measure resulted in an increase of one percent or more in premium costs.¹⁶⁴ Senator Domenici found the Gramm amendment to be acceptable,¹⁶⁵ and the Senate adopted it as part of approving the parity provision.

Unlike the broader parity measure adopted by the Senate in April 1996, which ultimately died in the House, September’s scaled-back version met with success in the lower chamber. Because the Mental Health Parity Act of 1996 arose as a Senate

160. *See id.* The two senators had also introduced this more limited proposal as a stand-alone bill (with a total of 14 co-sponsors). *See* S. 2031, 104th Cong. (1996).

161. *See* 142 CONG. REC. S9953 (daily ed. Sept. 5, 1996).

162. *See id.* at S9916.

163. *Id.* at S9919 (statement of Sen. Conrad). Senator Wellstone has acknowledged that he and Senator Domenici scaled back their original parity measure substantially “to address cost concerns.” Paul Wellstone, *A Step Toward Equal Coverage for the Mentally Ill; Congress Must Require Health Insurance Parity*, ROLL CALL, Sept. 16, 1996, available in LEXIS, News Library, ROLLCL File. The exemption for employers with fewer than 26 employees was also motivated by cost concerns. *See id.*

164. *See* 142 CONG. REC. S9926 (daily ed. Sept. 5, 1996). Senator Gramm had earlier spoken in opposition to the parity measure. *See id.* at S9922-25.

165. *See id.* at S9927.

amendment to a House bill, the Senate version of the overall bill differed from the previously adopted House version. Accordingly, the Congressional leadership sent the entire bill to a conference committee to work out the differences between the House and Senate versions. On September 11, 1996, in a non-binding vote, the House overwhelmingly "asked its conferees on the FY97 VA-HUD appropriations bill to support" the scaled-back mental health parity amendment along with two other health-related amendments.¹⁶⁶ That non-binding vote, together with further lobbying efforts by Senator Domenici with the House leadership, led to the retention of a further scaled-down version of the Mental Health Parity Act of 1996 in the final conference report.¹⁶⁷ Congress then adopted the overall bill, including the limited parity provision, on September 24, 1996.¹⁶⁸

The ultimate version of the Mental Health Parity Act of 1996 that emerged from the House-Senate conference committee is somewhat narrower in scope than the Senate version. The final bill makes the provisions inapplicable to employers with fifty or fewer employees, rather than twenty-five.¹⁶⁹ Also, the bill will not become effective until January 1, 1998,¹⁷⁰ and it has a sunset provision with a date of September 30, 2001.¹⁷¹ Like the Senate

166. *House Asks Conferees to Back Senate Health Measures*, NAT'L JOURNAL'S CONGRESS DAILY, Sept. 11, 1996, available in LEXIS, News Library, CNGDLY File. The vote was 392-17, and also covered a provision barring insurers from forcing women to leave a hospital less than 48 hours after giving birth and a measure providing new benefits for certain ill children of veterans who were exposed to Agent Orange. *See id.*

167. *See* H.R. CONF. REP. NO. 104-812, at _ (1996), in 142 CONG. REC. H10733, H10745-46 (daily ed. Sept. 20, 1996). President Clinton also urged Congress to pass the parity proposal. He stated, "People with mental illness have faced discrimination in health insurance coverage for far too long. It is time that we take steps to end this inequality." Elizabeth Shogren, *Insurance Bill Offers Parity for Mental Illness*, L.A. TIMES, Sept. 18, 1996, at A1.

168. *See* Jackie Frank, *House Clears Maternity Stay, Mental Health Care*, Reuters, Sept. 24, 1996, available in LEXIS, News Library, TXTNWS File (reporting that the House approved the bill 388-25, and that the Senate considered the bill passed upon House approval).

169. *See* H.R. CONF. REP. NO. 104-812, in 142 CONG. REC. H10733, H10745 (daily ed. Sept. 20, 1996). The carve-out for employers with 50 or fewer employees is comparable to the definition of "small employer" found in the Kennedy-Kassebaum bill enacted by the 104th Congress. *See* Health Insurance Portability And Accountability Act of 1996, Pub. L. No. 104-191, § 2791, 110 Stat. 1936.

170. *See* H.R. CONF. REP. NO. 104-812, in 142 CONG. REC. H10733, H10745 (daily ed. Sept. 20, 1996).

171. *See id.* The delayed effective date, as well as the sunset provision, have caused advocates to be concerned that a later Congress will attempt to undo this

version, the bill requires parity only with respect to annual caps or lifetime limits on mental health benefits.¹⁷² Also, the final bill retains the Gramm amendment to allow an exemption in the event that the new coverage increases the costs of an employer's health plan by one percent or more.¹⁷³ Additionally, unlike the Senate version of the amendment, the final measure set forth in the conference report includes language to indicate clearly that the parity requirements will apply to both health insurance plans and fully self-funded plans covered by ERISA.¹⁷⁴ Finally, the House-Senate conferees expressed their intent that "the application of the [bill's] preemption provision should permit the operation of any State law or provision which requires more favorable treatment of mental health benefits under health insurance coverage than that required" in the new federal law.¹⁷⁵ Thus, the limited nature of the new federal parity provision should not act to preempt broader parity provisions enacted by state legislatures.

The main thrust of the parity provision as enacted will be to preclude employers and health plans from setting minimal annual and lifetime caps on available insurance benefits for mental health treatment while maintaining substantially higher limits for other medical conditions.¹⁷⁶ Although the bill represents a hard-fought victory for advocates for persons with mental illness, the final version is just a start toward insurance equality. One report described the final version as "a mere shadow of the full mental health 'parity' amendment."¹⁷⁷ For example, the bill will have no impact on such common insurance practices as the

year's enactment. Telephone Interview with Dr. Laura Lee Hall, *supra* note 151.

172. See H.R. CONF. REP. NO. 104-812, in 142 CONG. REC. H10733, H10745 (daily ed. Sept. 20, 1996).

173. See *id.*

174. See *id.* (section 702 of the act specifically amends ERISA). Although the sponsors likely intended the Senate version to apply to fully self-funded plans governed by ERISA, that earlier version of the bill was not specific in this regard. The ultimate enactment made specific amendments to ERISA to codify the parity requirements directly.

175. *Id.* at H10756.

176. As Senator Wellstone explained, "If a health plan has a \$1 million lifetime aggregate limit for such diseases as cancer, heart disease, and diabetes, then a lower lifetime limit could not be established for mental illnesses. Health plans now typically impose lifetime limits of \$50,000 and annual caps of \$10,000 for treatment of mental illness." Wellstone, *supra* note 163.

177. *Health Provisions Finalized in VA-HUD Measure*, NAT'L JOURNAL'S CONGRESS DAILY, Sept. 20, 1996, available in LEXIS, News Library, CNGDLY File.

requirement of substantially higher deductibles and higher co-payments to coverage for mental health benefits than for those provided for other ailments. Employers and health plans can also continue to consider managed care alternatives. Moreover, employers and health plans can now set even higher deductibles or co-payments as a means of controlling the new costs, or they could drop mental health coverage altogether.¹⁷⁸ These entities can also comply with the new requirements, but then establish an aggregate limit for health and mental health benefits that falls below the amount previously authorized just for physical health.¹⁷⁹ Also, because the bill exempts employers with less than fifty employees, the new provisions will not reach many employees who suffer from mental illnesses. Finally, the Gramm exemption that allows an employer to opt out of the parity requirement if the new measure increases the costs of its policy by one percent or more is ambiguous. If the anticipated cost predictions are accurate, the Gramm amendment should seldom come into play.¹⁸⁰ The language used in the amendment, however, is unclear with respect to when the one percent calculation should be conducted. It is conceivable that an insurer might merely offer a policy to an employer that complies with the new law, but which "conveniently" includes a price that is greater than one percent over previous charges. The employer could then decline the coverage. Congress, however, clearly did not intend such collusion. Any cost increases should be based on actual experience and actuarial data, not collusive pricing.

Despite the final bill's shortcomings, the Mental Health Parity Act of 1996 represents a huge step forward in overcoming years of discrimination against persons with mental illness. As Senator Domenici described, the enactment is "a historic step, a breakthrough, for the severely mentally ill" and Congress has taken "one step to get rid of the terrible stigma and discrimination that's based on mystique, mystery and Dark Age concepts."¹⁸¹

178. See Robert Pear, *Experts Foresee Health Plan Shift for Mental Care*, N.Y. TIMES, Sept. 21, 1996, at § 1, 1.

179. See George Rodrigue, *Panel OKs Additional Health Care; Bill Could Aid New Moms, Mentally Ill*, DALLAS MORNING NEWS, Sept. 20, 1996, at 1A.

180. *But see* Pear, *supra* note 178 (quoting Susan D. Moriconi, the health benefits manager for Hewlett-Packard, as stating, "They're absolutely, positively wrong on that. A large number of employers and plans will have an increase of more than 1 percent.").

181. Robert Pear, *Conferees Agree on More Coverage for Health Care*, N.Y.

And, even though the bill is substantially narrower than originally conceived, it is "significant—both symbolically and financially—for those who suffer from mental illness."¹⁸² As the other chief proponent of the bill, Senator Wellstone, described, "It is a crucial and affordable step toward ending the stigma and the most egregious form of discrimination against Americans suffering from mental illness."¹⁸³ Thus, both principal co-sponsors of the legislation have indicated that this year's enactment represents just a first step toward their goal of equal insurance treatment for persons with mental illness.

C. The Uninsured

Even if a future Congress enacts more expansive parity legislation at a later date, such a measure (or incremental measures) will not necessarily extend insurance coverage to all persons suffering from mental illness. Parity legislation typically has served to require equivalency in coverages for mental illness for *existing* and future health insurance policies. These enactments do not, in and of themselves, extend an umbrella of insurance protection to persons with mental illness who have no insurance.¹⁸⁴ A far more sweeping effort at health care reform will be needed to address issues surrounding the large number of Americans with mental illness who lack health insurance altogether.

TIMES, Sept. 20, 1996, at A1. Senator Domenici added that "[b]y mandating benefit parity, Congress is sending 'a little ray of hope to the millions of American people' that they no longer will have 'trivial coverage' for mental disorders." Jerry Geisel, *Senate Approves Mental Health, Maternity Reforms*, BUS. INS., Sept. 9, 1996, at 1, available in LEXIS, News Library, BUSINS File.

182. Elizabeth Shogren, *Insurance Bill Offers Parity for Mentally Ill*, L.A. TIMES, Sept. 18, 1996, at A1. Shogren accurately summarized the tensions generated by the legislative battle: "To advocates for the mentally ill, the bill offers an opportunity to begin reducing the traditional disparity between mental and physical health benefits. But to business and insurance interests, it is viewed as an unwarranted attempt by government to impose an unfunded mandate on private employers." *Id.*

183. *NAMI Heralds Historic Congressional Step Toward Ending Insurance Discrimination Against People With Severe Mental Illness*, PR Newswire, Sept. 19, 1996, available in LEXIS, News Library, US File.

184. See Shannon, *supra* note 4, at 374-75 (discussing issues relating to persons with mental illness who have no health insurance).

V. CONCLUSION

The United States Senate made a historic effort in 1996 in attempting to require full parity in insurance coverage for the treatment of mental illness. Never before had members of such a highly visible body spoken so openly about the potential for tragedy faced on a daily basis by millions of persons suffering from mental illness and their families. Although the full parity legislation was ultimately doomed to failure, its demise signaled only the beginning of the battle.¹⁸⁵ Indeed, despite the failure of the broad, initial Domenici-Wellstone measure, the very fact that the United States Senate considered and, at least temporarily, approved such an expansive provision served as a catalyst for Congress ultimately to enact a very limited parity compromise late in the 1996 legislative year. The 104th Congress' last-minute efforts to enact the limited parity provisions of the Mental Health Parity Act of 1996 have moved us forward a historic first increment.¹⁸⁶ Further Congressional action is needed, however, to secure full parity in coverage for mental illness. It is the only fair solution to continued, unwarranted discrimination. Moreover, parity is particularly compelling, necessary, and warranted in the case of serious mental illnesses with known, biological bases. If the Congress is going to act in an incremental fashion, the next logical increment should be parity for serious mental illnesses. Why should coverage for proven diseases of the brain be different from coverage for other diseases? In addition, most recent cost studies have revealed that the cost increases associated with full coverage for serious mental illness are modest, are cost-effective, and could even result in cost savings through shifts from public sector financing to the private arena.

185. For example, the National Alliance for the Mentally Ill responded to the initial parity measure's defeat by urging its members to focus on the failed bill in the 1996 Congressional elections: "The momentum we have gained by having the national media explore this issue in depth (whether they came in . . . on our side or not) should not be allowed to falter. The energy generated by the historic vote for parity by the U.S. Senate must be now directed toward the November [1996] elections." *Don't Stop the Parity Push Now*, NAMI ADVOCATE, July-Aug. 1996, at 1.

186. As Senator Wellstone observed on the Senate floor during debate over the measure, "I do want [Senate] colleagues to know that it is just an incremental step forward, but a significant one." 142 CONG. REC. S9918 (daily ed. Sept. 5, 1996) (statement of Sen. Wellstone).

Given the lack of adequate alternative solutions, it will take further efforts by a future Congress to secure fair health insurance coverage for millions of Americans who either suffer from serious mental illness or need treatment for other mental health disorders. As Senator Domenici explained on the Senate floor during consideration of the first Domenici-Wellstone Amendment, "I believe there is plenty of evidence that the discrimination continues. It grows more rampant. The stigma, since that discrimination is rampant, is growing instead of diminishing, in an era when knowledge is beginning to grow almost exponentially. So, now is the time."¹⁸⁷ Although 1996 turned out *not* to be the time for full parity, the limited parity measure that Congress ultimately enacted represents a tremendous first step, and the next Congress should take additional strides to assure that the *right* time for achieving parity comes sooner, rather than later or not at all.

187. 142 Cong. Rec. S3591 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici).