THE NATIONAL LAW JOURNAL

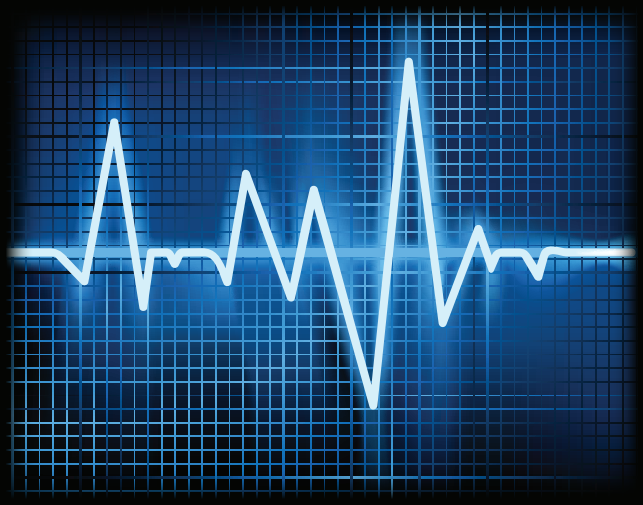
MARCH 10, 2014

An ALM Publication

HEALTH CARE

A SPECIAL REPORT

The Patient Protection and Affordable Care Act remains the big news for health care practitioners, and we explore two aspects of the law in this special report—how it could expand access to mental health care and how employers can take advantage of a reprieve from the legal mandate to provide health insurance. We also examine the long struggle to ensure equal access to medical trials for women and minority groups.



A Long Struggle for Mental Health Parity

The ACA's language in this area may prove its most profound contribution to the national welfare.

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As much as the Patient Protection and Affordable Care Act (ACA) profoundly changed the health care system in the United States, at least one thing has clearly remained the same: the central role played by private health insurers. Although the discussion surrounding the ACA has focused on health care exchanges, individual mandates and coverage for the uninsured, much less talked about are the profound changes that the ACA and related statutes have made to the coverage that private insurers are legally required to provide. If these legal mandates were followed—particularly as they relate to mental health parity—it would do more to improve the health of everyday Americans than all of the other provisions of the ACA put together. However, it appears that they are not.

For centuries, advocates struggled to convince the public and policy makers that mental health care was and should be treated just like physical health care. From ancient times to the 18th century, mental illness was attributed to supernatural phenomena and acceptable treatment options included exorcism, bloodletting and trephining (drilling a hole into a person's skull to release evil spirits). Although the public and medical community recognized in the 19th and early 20th century that mental illness was a medical condition akin to physical disease, patients still faced widespread stigmatization and treatment options were often expensive, limited, not covered by insurance and ineffective. The widespread use of lobotomies and/or confinement in the middle part of the 20th century to treat people with schizophrenia and other persistent mental illness provides a case in point.

In the second half of the 20th century, mental health treatment became exponentially more effective and attitudes toward the mentally ill softened considerably. Although private insurers publicly asserted that they were working to promote mental health treatment, they routinely provided much greater coverage for physical illness than mental illness in an apparent effort to reduce costs.

AP PHOTO/LAUREN VICTORIA BURKE

PATRICK KENNEDY: "Access to mental health services is one of the most important and most neglected civil rights issues facing the nation." He sponsored the House version of a 2008 reform bill.

1996 REFORM

In 1996, this situation reached an inflection point when Congress enacted the Mental Health Parity Act of 1996 sponsored by sens. Paul Wellstone and Pete Domenici. The 1996 act sought to protect access to health insurance for mental illness by prohibiting disparate annual and lifetime limits for mental health benefits compared to medical/surgical benefits. Yet, it contained many exceptions and other restrictions limiting its scope. Not surprisingly, private insurers took advantage of the loopholes and found alternative ways to discourage mental health treatment, including by covering lower percentages of mental health costs than medical/surgical costs; imposing higher coinsurance rates on mental health benefits; and restricting the number of outpatient visits and inpatient hospital days for mental health patients, but not for medical/surgical patients. According to the U.S. Government Accountability Office, nearly 90 percent of plans imposed at least some restrictions on coverage for mental health services that were not imposed on medical or surgical claims, requiring patients either to pay higher costs or forgo treatment. U.S. Gov. Accountability Office, Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited 5 (2000).

During the following 12 years, many states, including New York, adopted legislation governing mental health parity, and some courts found traditional mental illnesses to be physical in nature, thus qualifying for medical/surgical coverage. Still, most mental health patients faced higher health care costs and discriminatory practices. See generally A Piecemeal, Step by Step Approach Toward Mental Health Parity, Suffolk U. J. Health & Biomedical Law at 279, 287-91.

Finally, in 2008, Congress felt the need to act again. It passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, also known as the Federal Parity Act. The clear intent was to address discrimination by insurers against the mentally ill and close the loopholes in the 1996 act. As one of the primary sponsors, Rep. Patrick Kennedy, noted: "Access to mental health services is one of the most important and most neglected civil rights issues facing the nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society." 153 Cong. Rec. S 1864 (daily ed. Feb. 12, 2007).

PARITY FOR 'TREATMENT LIMITATIONS'

The Federal Parity Act was incorporated into subchapter 1 of the Employee Retirement Income Security Act, codified at 29 U.S.C. 1185a, the federal statute governing private-employee benefit plans. Broadly speaking, it prohibits insurance discrimination against mental health conditions by requiring parity with respect to "treatment limitations" imposed on coverage for such services. Recently released final regulations flesh out the broad mandates of the act by defining "treatment limitations" as being either "quantitative" or "nonquantitative," and including "limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment." 29 CFR 2590.712(a).

While quantitative treatment limitations are those that "are expressed numerically (such as 50 outpatient visits per year)," nonquantitative treatment limitations are those that "otherwise limit the scope or duration of benefits for treatment under a plan," including such things as "medical management standards limiting or excluding benefits based on medical necessity," "refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)," and "exclusions based on failure to complete a course of treatment." 29 CFR 2590.712(c)(4)(ii).

Demonstrating the significant national support for mental health parity, the ACA applied these requirements to non-ERISA plans. As a result, almost all Americans with insurance are now entitled to the act's protections.

These legislative changes could—and should—have a widespread and positive impact on society. According to the National Alliance on Mental Illness, approximately 61.5 million Americans—or one in four adults—experience some form of mental illness in a given year, while 13.6 million—or one in 17—suffer serious mental illness, such as schizophrenia, major depression or bipolar disorder. It is estimated that serious mental illness costs more than $193 billion in lost earnings every year. Few debates about homelessness, prison reform, education, gun violence or many other high-profile issues do not inevitably circle back to questions about mental health care. Indeed, those advocating for improvements to that system reach across the political spectrum, as illustrated by the National Rifle Association's recent demand that policymakers fix our "broken mental health care system."

Although the Federal Parity Act was designed to expand coverage and ensure treatment for mental illness, and there are robust regulations implementing and interpreting the law, it has not been enforced. There are few reported judicial decisions addressing it and even fewer administrative actions by the federal government to address perceived statutory violations. The same is true of state insurance commissioner enforcement of state mental health parity laws.

POSSIBLE TURNING POINT

Three recently filed cases, however, may signal a turning point if the courts conclude that the plaintiffs' claims are meritorious. In *K.M. v. Regence Blueshield*, the court recently certified a class of children who suffer from developmental disabilities (including autism), in an action that alleges that the defendant insurer routinely refuses to cover standard forms of treatment that are proven to be effective, in violation of Federal Parity Act and Washington state's mental health parity law. *K.M. v. Regence Blueshield*, No. 13-1214, U.S. Dist. Lexis 9156 (W.D. Wash. Jan. 24, 2014), appeal docketed, No. 14-35108 (9th Cir. Feb. 13, 2014).

In *Fradenburg v. United Behavioral Health*, plaintiffs seek certification of a class of insurance beneficiaries to challenge the defendant insurer's policy of requiring concurrent and prospective reviews of routine outpatient mental health treatments when no such reviews were conducted for routine outpatient treatments for other medical conditions. *Fradenburg v. United Behavioral Health*, No. 1401650 (Calif. Super. Ct. filed May 8, 2012).

In *N.Y.S. Psych. Assoc. Inc. v. UnitedHealth Group*, plaintiffs are challenging a slew of internal policies adopted by the defendant insurer, including those that impose a heightened evidentiary burden of proof on mental health care claimants and require such claimants to prove that their conditions will significantly and imminently deteriorate without the care requested even though similar requirements are not imposed on those seeking medical/surgical benefits. *N.Y.S. Psych. Assoc. Inc. v. UnitedHealth Group*, No. 13 Civ. 1599, 2013 WL 5878897 (S.D.N.Y. Oct. 31, 2013), appeal docketed, No. 14-20 (2d Cir. Jan. 2, 2014).

Although insurers argue that health care costs are spiraling out of control and that their restrictions on mental health care are necessary to hold down costs, the public and its elected representatives appear committed to the idea that mental health care must be more accessible and provided on equal terms with physical health care. If the courts reject the effort by private litigants to enforce the mental health parity laws, it seems all but certain that Congress and/or the states will again step into the breach (as Congress did when it tried to close loopholes in the 1996 law).

This time, however, policy makers would be required to go beyond parity and affirmatively mandate that certain types of mental health treatment be covered. This is what Congress did, for example, when it required insurers to cover no less than 48 hours of hospital care for a mother and child following childbirth.

Whether such statutorily mandated coverage will be necessary will depend, in large measure, on how the courts resolve these three cases. These decisions will tell us whether the Federal Parity Act was the culmination of a decadeslong struggle by mental health care advocates that led to meaningful reform, or whether it was a failed legislative effort (like the 1996 act) that required further legislation as we moved inexorably toward real reform and meaningful improvement in treatment of mental illness.

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