AFFORDABLE MENTAL HEALTH CARE IN THE POST HEALTHCARE REFORM ERA

I. INTRODUCTION

On January 8, 2011, a young man walked on the parking lot of a Safeway supermarket in Tucson, Arizona, shot U.S. Representative Gabrielle Giffords in the head, and opened fire on the gathered crowd.[1] Congresswoman Giffords was one of fourteen people wounded; among the six killed were a federal judge and a nine year old girl.[2] What followed was a debate on the motives of the alleged shooter, Jared Loughner, and his apparent struggle with mental illness.[3]

The Arizona shooting sparked a debate on mental health in the United States and the need for an effective mental health system.[4] Implicit in this debate was the recognition that the mental health system in the United States is seriously inadequate. A recent report grading the quality of the mental health system in the United States gave the country an overall grade of "D."[5] An effective mental health system must offer

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1. *See* Shailagh Murray & Sari Horwitz, *Rep. Gabrielle Giffords Shot in Tucson Rampage; Federal Judge Killed*, WASH. POST (Jan. 9, 2011, 12:00 AM), http://www.washingtonpost.com/wp-dyn/content/article/2011/01/08/AR2011010802422.html.

2. *Id.*

3. *See, e.g.*, John Cloud, *The Troubled Life of Jared Loughner*, TIME (Jan. 15, 2011), http://www.time.com/time/magazine/article/0,9171,2042358-1,00.html; Adam B, *Jared Loughner, Mental Health and the Law*, DAILY KOS (Jan. 10, 2011, 9:45 PM), http://www.dailykos.com/story/2011/01/10/935116/-Jared-Loughner,-Mental-Health-and-the-Law.

4. *See, e.g.*, Kate Pickert & John Cloud, *If You Think Someone is Mentally Ill: Loughner's Six Warning Signs*, TIME (Jan. 11, 2011), http://www.time.com/time/nation/article/0,8599,2041733,00.html; Doug Mataconis, *Jared Loughner And The Sorry State Of Mental Health Care*, OUTSIDE THE BELTWAY (Jan. 10, 2011), http://www.outsidethebeltway.com/jared-loughner-and-the-sorry-state-of-mental-health-care/; Andrew Price, *Jared Loughner, Schizophrenia, and Mental Health Care in America*, NURSING LINK (Jan. 11, 2011), http://nursinglink.monster.com/news/articles/21254-jared-loughner-schizophrenia-and-mental-health-care-in-america. Surprisingly, since the shooting, few legislative initiatives aimed at supporting mental health have been suggested. Nor have any serious legislative initiatives aimed at restricting access to firearms, especially restrictions aimed at individuals with mental illnesses, been proposed.

5. NAT'L ALLIANCE ON MENTAL ILLNESS, *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness*, NAMI.ORG (Mar. 2009), http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459 [hereinafter *Grading the States 2009*]. No state received an "A" grade and only six states received "B" grades. *Id.*

quality treatment options regardless of an individual's ability to pay.[6] It has been argued that establishing an effective mental health system requires bold and effective political action that fully integrates mental health into the country's overall health system, and provides for inclusion of all individuals with mental illnesses.[7]

This Note will argue that recent changes in the health care law in the United States will help to improve the ability of individuals to receive treatment for mental health illnesses, but will be ineffective for individuals with severe and persistent mental illnesses (SPMI). In order to reach this conclusion, Part II of this Note will discuss the different health care options available to individuals with mental illnesses. This will be followed by an exploration of how mental health legislation has developed in recent years, and the shortcomings of prior legislation that led to the enactment of subsequent laws. Part III will examine how the most recent health legislation will affect the ability of individuals to receive affordable mental health care. Finally, Part IV of this Note will conclude that the most recent health legislation will be partially successful in improving mental health coverage for certain individuals, but will not address the needs of individuals with *serious* mental illnesses.

II. BACKGROUND

A. Developments in Mental Health Legislation Before the Enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Patient Protection and Affordable Care Act (PPACA)

1. Defining Mental Illness

The definition of what constitutes mental illness can vary greatly depending on the context in which the term is used. For example, the National Alliance on Mental Illness ("NAMI") defines mental illness as any medical condition that affects an individual's mood, thinking, feeling and interactions with others, reducing the person's ability to accomplish normal daily tasks.[8] NAMI defines serious mental illness to include

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at ix. Eighteen states received "C" grades including Arizona, the home state of Jared Loughner. *Id.* at ix, xii. In addition, twenty one states received "D" grades, and six states received "F" grades. *Id.* at ix.

6. *Id.* at 3.

7. *See Grading the States 2009*, *supra* note 5, at 2.

8. *See* NAT'L ALLIANCE ON MENTAL ILLNESS, *What is Mental Illness: Mental Illness Facts,* NAMI.ORG,

"major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder."[9]

Insurance plans have no universal definition of mental illness. Instead, the definitions differ among insurance companies and plans. Insurance companies are free to determine what constitutes a mental illness under the plans they offer. Where an insurance plan's definition of mental illness is unclear or ambiguous, courts are split in their approaches to defining mental illness. For instance, in *Simonia v. Glendale Nissan/Infiniti Disability Plan,* the Ninth Circuit upheld an insurance plan that defined mental illness as any disorder considered a mental disorder according to the American Psychiatric Association.[10] In *Kunin v. Benefit Trust Life Ins. Co.*, where the insurance plan's definition of mental illness was unclear, the Ninth Circuit affirmed the district court's decision that defined mental illness as "a behavioral disturbance with no demonstrable organic or physical basis . . . . [stemming] from [a] reaction to environmental conditions as distinguished from organic causes."[11] Conversely, in *Brewer v. Lincoln Nat. Life Ins.*, the Eighth Circuit expressly refused to follow the Ninth Circuit's mental illness definition.[12] The court in *Brewer* held that an illness would be considered a mental illness based on symptoms a layperson would characterize as a mental illness regardless of the cause.[13] Therefore, before the enactment of the Mental Health Parity and Addiction Equity Act ("MHPAEA"), and the Patient Protection and Affordable Care Act ("PPACA"), by carefully crafting insurance coverage plans, public and private insurance providers were able to dictate to what extent they would cover mental illnesses by employing different definitions of "mental illness." This meant that conditions commonly considered mental illnesses could be

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http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm (last visited Mar. 31, 2011).

9. *Id.*

10. Simonia v. Glendale Nissan/Infiniti Disability Plan, 378 F. App'x 725, 725 (9th Cir. 2010) (holding a diagnosis of depression is a mental disorder within the meaning of a disability plan).

11. Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 538 (9th Cir. 1990) (stating that autism is not a mental illness). However, "Autism Spectrum Disorder" is considered a mental illness by NAMI. *See* NAT'L ALLIANCE OF MENTAL ILLNESS, *Autism Spectrum Disorders Fact Sheet*, NAMI.ORG, http://www.nami.org/Template.cfm?Section=Helpline1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=65961 (last visited Mar. 31, 2011).

12. Brewer v. Lincoln Nat'l Life Ins., 921 F.2d 150, 154 (8th Cir. 1990) (holding that affective mood disorder was a mental illness).

13. *Id.*

excluded under these definitions, and people with identical conditions could be treated differently.

2. Public Insurance Options for Mental Illness

Federal and state Medicaid programs provide the best option for many individuals who require health insurance coverage for mental illnesses.[14] In fact, Medicaid accounts for over half of the public expenditures on mental health.[15] Though provisions in federal Medicaid law limit mental health services to individuals who only qualify for Medicaid because of their low-income status,[16] states retain discretion to provide medical benefits to "less needy" individuals whose income makes them ineligible for aid, but who do not have the resources to meet the cost of necessary medical care.[17] Accordingly, every state Medicaid program offers some form of mental health service.[18]

Medicare is another federal program that provides health insurance coverage (including mental health services) to individuals over sixty-five years old and to disabled individuals who receive Social Security Disability Insurance benefits.[19] As of September 2010, Medicare provided coverage to forty-seven million Americans, with over a quarter of them requiring coverage for a cognitive or mental impairment.[20]

The State Children's Health Insurance Program ("SCHIP") is a program similar to Medicaid that provides health insurance coverage to

14. Medicaid is a federal-state program that provides states with financial assistance in paying for medical treatment for financially needy individuals. *See* Schweiker v. Hogan, 457 U.S. 569, 571-72 (1982). Participating states are required to provide coverage to individuals classified as "categorically needy" and have the option of providing coverage to individuals classified as the "medically needy." *Id.*

15. JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, *The Role of Federal Programs: Medicaid, SCHIP & Medicare*, BAZELON.ORG, http://bazelon.org.gravitatehosting.com/LinkClick.aspx?fileticket=eonA0y9yJb8%3d&tabid=220 (last visited Mar. 31, 2011).

16. *Id.* at 3.

17. *See Hogan*, 457 U.S. at 573.

18. *See* Gary Smith et al., *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*, U.S. DEP'T OF HEALTH AND HUMAN SERV. OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION 2 (2005), *available at* http://aspe.hhs.gov/daltcp/reports/handbook.pdf.

19. *See* Schweiker v. McClure, 456 U.S. 188, 190 (1982). *See also* KAISER FAMILY FOUNDATION, *Fact Sheet: Medicare at a Glance* 1-2 (2010), *available at* http://www.kff.org/medicare/upload/1066-13.pdf.

20. *See* KAISER FAMILY FOUNDATION, *supra* note 19.

children from low income families.[21] States have flexibility in determining what services are covered under SCHIP, and may either create a stand-alone insurance program, expand the existing Medicaid program, or combine both options.[22] Under the 2009 amendment to the Children's Health Insurance Program (CHIP), children that qualify for coverage under the program also qualify for some level of mental health treatment.[23]

3. Mental Illness and Private Health Insurance Plans

Beyond Medicaid and the other forms of public health insurance options, employer-based insurance plans account for the largest private health insurance plans available to individuals.[24] Most private insurance companies offer some form of mental health coverage, but with fewer services, higher premiums, and shorter time periods.[25]

In response to this disparity in the treatment of physical illnesses and mental illnesses, numerous legal challenges have been brought against such insurance company practices.[26] In lawsuits brought under the Americans with Disabilities Act (ADA),[27] courts have generally upheld

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21. *See* 42 U.S.C. § 1397aa (2006). *See also* New York v. U.S. Dep't of Health & Human Serv., No. 07 Civ. 8621(PAC), 2008 WL 5211000, at *3 (S.D.N.Y. Dec. 15, 2008).

22. *See U.S. Dep't of Health & Human Serv.*, 2008 WL 5211000, at *3.

23. Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 401(a)(3), 123 Stat. 8, 72. As of December 2009, the Children's Health Insurance Program has enrolled over five million children across every state and the District of Columbia. *See* KAISER FAMILY FOUNDATION, *CHIP Enrollment: December 2009 Data Snapshot*, 6, http://kff.org/medicaid/upload/7642-05.pdf (last visited Apr. 1, 2011).

24. *See* Robert W. Fairlie & Rebecca A. London, *The Dynamics of Health Insurance Coverage: Factors Correlated with Insurance Gain and Loss Among Adults*, U.S. DEP'T OF LAB. 2 (Aug. 31, 2005), http://www.dol.gov/ebsa/pdf/DOLHealthDynamics.pdf. As of 2003, 72% of individuals in the U.S. with health insurance coverage belonged to an employer-based insurance plan. *Id.* Individual health plans are the least common form of health plans, covering 14 million individuals, compared with 157 million individuals covered by employer-sponsored plans. KAISER FAMILY FOUNDATION, *Survey of People Who Purchase Their Own Insurance* 1 (2010), http://kff.org/kaiserpolls/upload/8077-R.pdf.

25. Stacey A. Tovino, *Neuroscience and Health Law: An Integrative Approach?*, 42 AKRON L. REV. 469, 477-78 (2009) (discussing the scope of health insurance benefits).

26. Some lawsuits focused on whether the illnesses were physical and not mental, and others focused on whether the treatments were of the type typically provided for physical or mental ailments. *See id.* at 478.

27. Under Title I of the ADA, 42 U.S.C. § 23223(b)(1) (2006), an employee cannot be discriminated against with respect to the terms of conditions of their employment on the basis of their disability. *See* Ford v. Schering-Plough Corp., 145 F.3d 601, 605, 608

employer-provided insurance plans that offered better coverage for services arising from physical illnesses than those resulting from mental illnesses.[28] Similarly, some courts have upheld the disparate treatment of mental and physical illnesses in lawsuits brought under the Employee Retirement Income Security Act (ERISA).[29] These rulings gave insurance companies the legal precedent that allowed them to define what constituted mental illness. The rulings also provided tacit approval of the insurance industry's practice of treating physical and mental illnesses differently.

B. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

In response to the disparate treatment of mental illness within insurance plans, Congress enacted the Mental Health Parity Act of 1996 (MHPA).[30] Prior to the passing of the MHPA, fifteen states had enacted some form of mental parity law; the MHPA was an attempt to create a federal parity law.[31] Under the MHPA, insurance companies did not have to cover mental illnesses under their health plans, but if they did offer mental health benefits, they had to apply the same annual and lifetime dollar limits for physical and mental illnesses.[32] However, insurance providers could set different dollar limits on co-pays, premiums, and deductibles.[33] This meant that insurance companies could still discriminate against individuals with mental illness by requiring higher co-pays, premiums, and deductibles.

(3d Cir. 1998) (holding disparate treatment of physical illnesses and mental illnesses under employee insurance plan does not violate the ADA).

28. *See Ford*, 145 F.3d at 605, 608. *See also* Lewis v. Kmart Corp., 180 F.3d 166, 170 (4th Cir. 1999); Parker v. Metro. Life Ins. Co., 121 F.3d 1006, 1008 (6th Cir. 1997).

29. *See* Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc., 125 F.3d 794, 799 (9th Cir. 1997); Prudential Ins. Co. of Am. v. Doe, 140 F.3d 785, 791 (8th Cir. 1998). ERISA was enacted to protect employees enrolled in employer run benefit plans including group health plans. *See* Employee Retirement Income Security Act, 29 U.S.C. § 1001 (2006).

30. Mental Health Parity Act, Pub. L. No. 104-204, 110 Stat. 2874 (1996).

31. Harold E. Varmus, *Parity in Financing Mental Health Services: Managed Care Effects on Cost Access, and Quality: An Interim Report to Congress by the National Advisory Mental Health Council*, NAT'L INST. OF MENTAL HEALTH 7, 50-52 (1998), *available at* http://www.mentalhealth.gov/about/advisory-boards-and-groups/namhc/reports/nimh-parity-report.pdf.

32. *Id. at* 5-6.

33. *See id.* at 5 n.3. In addition, the MHPA only applied to employer-provided group health plans with more than fifty employees, and plans that could show an increase in the annual premium costs of more than 1% were exempted from the MHPA requirements. *Id.* at 5-6.

Following MHPA's enactment and in response to its shortcomings, Congress enacted the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[34] as part of the Emergency Economic Stabilization Act of 2008. The MHPAEA applies to both group health insurance plans and individual plans.[35] It also applies to services performed by out-of-network providers.[36] Like the MHPA, the MHPAEA applies to insurance plans that offer mental health services, but does not require those plans to offer mental services.[37] Also, under the MHPAEA, the definition of a mental health condition would be determined by the terms of the plan and in accordance with state and federal laws.[38]

The MHPAEA provides that insurance companies that offer medical and surgical benefits, as well as mental or substance abuse benefits, may not place different lifetime limits on those benefits.[39] In situations where the plan offers different aggregate lifetime limits for different categories of medical services, the aggregate lifetime limit for mental services can not be less than the weighted average of the lifetime limit of the other services.[40] Under the MHPAEA, the financial requirements for mental health services cannot be more restrictive than the predominant financial requirements of substantially all medical services, nor can a separate cost

34. Mental Health Parity and Addiction Act, Pub. L. No. 110-343, 122 Stat. 3765 (2008) (codified as amended at 29 U.S.C. § 1185a (2009), 42 U.S.C. § 300gg-5 (2009)). The MHPAEA was meant to build on the MHPA by addressing the shortcomings of the MHPA, such as prohibiting different co-pays, premiums, and deductibles for mental illnesses. *See* Fred Frommer, *After 12 Years, Wellstone Mental Health Parity Act is Law*, MPR NEWS (Oct. 3, 2008), http://minnesota.publicradio.org/display/web/2008/10/03/parity_finalpassage/.

35. ERISA was amended to apply to group plans, and the Public Health Service Act was amended to apply to individual plans. *See generally* Mental Health Parity and Addiction Act, Pub. L. No. 110-343, 122 Stat. 3765 (2008). Since the amendments to both Acts are essentially the same, I will focus my analysis on the ERISA amendments codified at 29 U.S.C. § 1185a.

36. *See* 29 U.S.C. § 1185a(a)(5).

37. *See id.* § 1185a(b).

38. *See id.* § 1185a(e)(4). Determining the definition of what constitutes a mental condition allows the insurers to determine what treatments would be covered under their plans.

39. *See id.* § 1185a(a)(1). If the plan has no lifetime limit on medical services, then no lifetime limits can be placed on mental services. *Id.* § 1185a(a)(1)(A). However, if the plan has a lifetime limit on medical benefits, then the plan could either treat medical and mental services as having no distinction between both types of services or the plan may choose to have a separate aggregate lifetime limit for mental services that is not less than the applicable lifetime limit. *Id.* § 1185a(a)(1)(B)(i)-(ii).

40. *See id.* § 1185a(a)(1)(C). The MHPAEA also makes the rules applicable to lifetime limits apply equally to annual limits. *See id.* § 1185a(a)(2).

sharing requirement be applied only to mental services.[41] In addition, there may not be separate or more restrictive treatment limitations for mental health services.[42]

The determination of what mental health services are medically necessary will be made according to the rules set forth in each plan.[43] However, to ensure that the mentally ill are not discriminated against, the plan administrator must make this information available to plan participants upon request.[44] Moreover, the plan administrator must also make available upon request any reason for the denial of payment or services under the plan.[45]

Finally, the MHPAEA does offer a small employer exemption from the parity requirements to group plans for employers who had fewer than fifty employees in the preceding calendar year.[46] Therefore, if as a result of the MHPAEA the total costs of the plan would exceed two percent on the first year and one percent for each subsequent year, then the MHPAEA applies to the plan and the plan may be exempted from the parity requirements.[47] Partly because the MHPAEA did not require insurers to cover mental health, legislation was required to fix the gaps in coverage that allowed mental health to be excluded from many plans.

C. The Patient Protection and Affordable Care Act (PPACA)

1. The Effect of the PPACA on Health Insurance Practices

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) became law.[48] The PPACA makes sweeping changes to the

41. *See id.* § 1185a(a)(3)(A)(i). "[D]eductibles, copayments, coinsurance, and out-of-pocket expenses" are expressly included in the definition of "financial requirements." *Id.* § 1185a(a)(3)(B)(i).

42. *See* 29 U.S.C. 1185a(a)(3)(A)(ii). Treatment limitations include "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." 29 U.S.C. § 1185a(a)(3)(B)(iii).

43. *See id.* § 1185a(a)(4).

44. *See id.*

45. *See id.*

46. *See id.* § 1185a(c)(1).

47. *See id.* § 1185a(c)(2). However, regardless of the increase in total costs, an employer may choose to apply the parity requirements to its mental plan. *See id.* § 1185a(c)(2)(A).

48. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of Titles 26 and 42 of the United States Code). The passing of the bill was very contentious and controversial; a number of lawsuits were filed challenging the constitutionality of the bill. *See, e.g.*, Florida v. U.S. Dep't of Health & Human Serv., 648 F.3d 1235 (11th Cir. 2011). In addition, members of the newly elected Republican majority in the House of Representatives passed a bill repealing the

legal landscape governing public and private insurance practices and would be administered by the Secretary of Health and Human Services (HHS).[49] The changes would be implemented over a number of years, with the final pieces of the legislation scheduled to be implemented on January 1, 2019.[50] Under the PPACA, insurance companies can no longer discriminate against individuals based on their health status or medical conditions, including any mental illness.[51] The PPACA also requires all individuals to maintain a minimum level of insurance coverage for themselves and their dependents beginning in 2013 or pay a penalty for each month the individual or his dependants are without health coverage.[52]

The PPACA also expressly prohibits an insurance provider from requiring a plan participant to pay a premium that is higher than a similarly situated participant based on the participant's health status.[53] However, this provision does not restrict the amount that may be charged for coverage under a group or individual insurance plan.[54] It also does not prevent insurance providers from offering premium discounts, lower deductibles, or co-payments for a participant's enrollment in a health promotion or disease prevention program.[55] In addition, insurance providers can no longer establish lifetime limits or dollar value limits on the plan participants or beneficiaries and must eliminate annual limits for plans issued after January 1, 2014.[56]

Furthermore, insurance providers can no longer rescind an individual's coverage under a health plan except after prior notice, and

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law. *See* H.R. 364, 112th Cong. (1st Sess. 2011). The bill is not likely to become law with a Democratic majority in the senate and a Democratic president who will likely veto any bill repealing the PPACA. This Note assumes that the PPACA would survive a constitutional challenge and that the attempts to repeal the Act will be unsuccessful. However, if these challenges to the PPACA are successful, the issues raised by this Note would remain, and the already limited options to mental health care would be even more pronounced.

49. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

50. *See id. See also* U.S. DEP'T OF HEALTH AND HUMAN SERV., *Understanding the Affordable Care Act: Timeline: What's Changing and When*, HEALTHCARE.GOV (Mar. 23, 2010), http://www.healthcare.gov/law/timeline/index.html.

51. *See* 42 U.S.C. § 300gg-4(a). Insurance companies may also not discriminate in favor of highly compensated individuals. *Id.* § 300gg-16.

52. *See* 26 U.S.C. § 5000A.

53. *See* 42 U.S.C. § 300gg-4(b)(1).

54. *See id.* § 300gg-4(b)(2)(A).

55. *See id.* § 300gg-4(b)(2)(B).

56. *See id.* § 300gg-11. This applies equally to group and individual plans. *Id.* For plans issued before January 1, 2014, the health insurance issuer "may only establish a restricted annual limit on . . . essential health benefits." *See id.* § 300gg-11(a)(2).

then only in situations involving fraud.[57] Nor can they increase the premiums of the insured upon the manifestation of a disease or disorder.[58] Individuals can also no longer be denied coverage because of an existing physical or mental condition.[59] However, the PPACA does not require insurance providers to "provide particular benefits other than those provided under the terms of [the] plan or coverage"[60] and insurance companies may also create limits or place restrictions on "the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage."[61] The PPACA, however, creates a temporary program that provides insurance coverage for individuals with preexisting conditions until January 1, 2014.[62]

The PPACA also requires a reporting system whereby insurance providers disclose what percentage of premiums actually go toward reimbursement for clinical services,[63] activities to improve the quality of health care,[64] and all other non-claims costs.[65] In addition, the HHS is required to develop standardized definitions that would explain and accurately describe the benefits and coverage under all group and individual insurance plans.[66] Also, group and individual health insurance providers are required to provide "essential health benefits" in accordance with federal and state laws.[67] "Essential health benefits" must include mental health and substance use disorder services.[68] HHS must

57. *See id.* § 300gg-12.

58. *See id.* § 300gg-12. The premiums of the employer may be increased, but upon the *manifestation* of a disease or disorder, genetic information about the group may not be used to further increase premiums. *See id.* § 300gg-1.

59. *See* 42 U.S.C. § 300gg-1.

60. *See id.* § 300gg-1(a)(2)(A).

61. *See id.* § 300gg-1(a)(2)(B).

62. *See id.* § 18001. Section 18001 operates as a stop-gap measure until State health insurance exchanges are created on January 1, 2014, to offer insurance for high risk individuals with preexisting conditions. *See id.*

63. *See id.* § 300gg-18(a)(1).

64. *See id.* § 300gg-18(a)(2).

65. *See* 42 U.S.C. § 300gg-18(a)(3).

66. *See id.* at § 300gg-15. These federal standards would also preempt any state standards. *See id.* at § 300gg-15(e). The Act would also include definitions for medical terms in categories that include "hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary [of HHS] determines are important." *See id.* § 300gg-15(g)(3).

67. *See id.* at § 18022.

68. Essential health benefits must also include: "[a]mbulatory patient services; [e]mergency services; [h]ospitalization; [m]aternity and newborn care; [m]ental health and substance use disorder services including behavioral health treatment; [p]rescription drugs; [r]ehabilitative and habilitative services and devices; [l]aboratory services;

ensure that the essential health benefits of each plan are of a type typically covered by employers, including multiemployer plans.[69]

2. The Effect of the PPACA on Public Health Services

The PPACA provides for the creation of state-run health benefit exchanges ("Exchanges") by January 1, 2014, to help individuals and qualified small employers buy qualified health plans.[70] The PPACA expressly applies the mental health parity provisions of the MHPAEA to all qualified health plans in the Exchanges in the same manner that it "applies to [other] health insurance issuers and group health plans."[71] The PPACA also enumerates the minimum level (the benchmark) of care that must be provided within state health plans.[72] Benchmark-equivalent coverage expressly includes mental health services.[73] Additionally, state health plans that are not Medicaid-managed, and which offer medical and surgical services as well as mental health services, must comply with the mental health parity requirements.[74] States may also provide services for home and community-based care for individuals who, but for those services, would require care in an institution for mental diseases for which the state would have to reimburse the costs.[75] The PPACA also has provisions that allow states to provide home health services for individuals with chronic conditions,[76] including "persistent mental health conditions."[77]

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[p]reventive and wellness services and chronic disease management; and [p]ediatric services, including oral and vision care." *Id.* § 18022(b)(1)(A)-(J) (internal enumerations omitted). The essential health benefits requirement also applies to individual health plans. *See id.* § 300gg-6.

69. *See id.* at § 18022(b)(2)(A).

70. *See id.* at § 18031.

71. *See* 42 U.S.C. § 18031(j).

72. *See id.* at § 1396u-7(a)(1)(A).

73. *See id.* at § 1396u-7(b)(2)(A)(v). Other benchmark services include: "[i]npatient and outpatient hospital services; [p]hysicians' surgical and medical services; [l]aboratory and x-ray services; [c]overage of prescription drugs; [w]ell-baby and well-child care, including age-appropriate immunizations; and [o]ther appropriate preventive services, as designated by the Secretary." *Id.* § 1396u-7(b)(2)(A)(i)-(vii) (internal enumerations omitted).

74. *See id.* § 1396u-7(b)(6)(A).

75. *Id.* § 1396n(k)(1).

76. *See id.* § 1396w-4(a).

77. 42 U.S.C. § 1396w-4(h)(1)(A)(ii)(III). "The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services." *Id.* § 1396w-4(h)(3).

The PPACA provides for the "Medicaid Emergency Psychiatric Demonstration Project," which for three consecutive years will allow a State Medicaid plan to make payments to any privately owned or operated mental health facility for procedures to stabilize emergency medical conditions for individuals covered under Medicaid, even those between ages twenty-one and sixty-five years old.[78] This will allow individuals with mental health emergencies to be treated at any emergency care center.[79]

With the passage of the PPACA, the federal government has put in place concrete measures aimed at removing barriers to mental health care for individuals. These measures are likely to increase access for more people who are currently without health coverage for their mental illnesses.[80] However, although the PPACA attempts to ensure that all individuals are receiving quality health care, only the most basic mental health services will be available to individuals with mental illness.[81] This means that adults with serious mental illnesses who are financially needy may be unable to receive adequate treatment under the PPACA due to the higher costs of treatment.[82] Accordingly, just as the PPACA cured the deficiencies of prior legislation, the current deficiencies in the PPACA will have to be corrected to ensure that all individuals with mental illness have access to quality care, regardless of the severity of their illness or their ability to pay for treatment.[83]

III. ANALYSIS

A. The PPACA Will Lead to More Health Insurance Options for Individuals with Mental Illness

The net effect of the MHPAEA and the PPACA will improve access to mental health services through private and public health insurance programs. Everyone will qualify for private health insurance under either an individual plan or an employer-sponsored plan.[84] Individuals who

78. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 326 at § 2707(a)-(d).

79. *See id.*

80. *See* discussion *infra* Part III.A.

81. *See* discussion *infra* Part III.B.

82. *See* discussion *infra* Part III.C-D.

83. *See* discussion *infra* Part III.E.

84. At least one commentator has argued that allowing everyone to qualify for health insurance cannot be achieved under a conventional insurance scheme that would require the elimination of most traditional insurance practices, resulting in the transformation of health insurance from its current form. *See* Wendy K. Mariner, *Health Reform: What's*

cannot afford private insurance will likely qualify for insurance under a public plan such as the state-run insurance Exchanges, Medicaid, Medicare, or SCHIP.

The PPACA also helps to reduce the number of individuals who rely on public programs because of their inability to pay by including provisions intended to make health insurance more affordable. One of the key provisions of the PPACA requires that insurance companies disclose the percentage of premiums that actually go towards health benefits.[85] This provision ensures that higher premiums are reflected by higher quality health care service.[86] Therefore, individuals who were previously paying higher premiums for substandard mental health coverage will be able to buy better mental health coverage for the same amount of money.

More importantly, more individuals will be able to get insurance coverage by 2014 when the state run health insurance Exchanges are fully implemented.[87] As a result of the PPACA, up to an estimated ten million previously uninsured individuals with mental or substance abuse illnesses would be covered by 2014.[88] This will make health insurance more accessible to more individuals, leading to better access to mental health care, and ultimately to better mental health outcomes.

Insurance Got to Do With It? Recognizing Health Insurance As a Special Species of Insurance, 36 AM. J.L. & MED. 436, 438 (2010).

85. Eighty to eighty-five percent of premiums must be spent on providing benefits to the insured. *See* 42 U.S.C. § 300gg-18(b)(1)(A)(i)(ii) (2006). *See also* U.S. DEP'T OF HEALTH & HUMAN SERV., *New Affordable Care Act Rules Give Consumers Better Value for Insurance Premiums*, http://www.hhs.gov/news/press/2010pres/11/20101122a.html (last revised Jan. 3, 2011).

86. The Department of Health and Human Services has also proposed regulations that would require insurance companies to justify any rate increases of more than ten percent. U.S. DEP'T OF HEALTH & HUMAN SERV., *Shining a Light on Health Insurance Rate Increases*, http://www.healthcare.gov/news/factsheets/ratereview.html, (last revised Dec. 21, 2010).

87. *See* 42 U.S.C. § 18031 (2006). More individuals may be compelled to purchase health insurance if the requirement that all eligible individuals purchase insurance or pay a penalty is implemented. *See* 26 U.S.C. § 5000A (2006). The Supreme Court is ultimately expected to rule on the constitutionality of that provision as well as the PPACA as a whole. The provision mandating that all individuals buy insurance or pay a penalty has been ruled unconstitutional by at least two federal judges. *See* Virginia *ex rel.* Cuccinelli v. Sebelius, 702 F. Supp. 2d 596, 598 (E.D. Va. 2010); Florida v. Dep't of Health & Human Serv., 648 F.3d 1235 (11th Cir. 2011).

88. *See* John O'Brien, *Strategic Initiative #4: Health Care Reform* 51 (2010), *available at* http://www.samhsa.gov/about/sidocs/healthCareReform.pdf.

B. The Most Common Insurance Plans Would Likely Only Provide Basic Mental Health Coverage

The high cost of treating severe or major mental illness will likely cause these conditions to be excluded from basic health insurance packages.[89] The PPACA allows insurance companies to provide four levels of coverage based on the benefits provided by the plan.[90] The benefits provided within each level of coverage will be fairly standard among different insurance plans.[91] This will allow insurers to provide coverage for more expensive mental ailments only in the higher level plans. Therefore, certain mental conditions that were restricted under some plans prior to the PPACA will continue to be excluded.[92]

In addition, the minimal level of mental health coverage that was provided prior to the PPACA would likely be sufficient to meet the requirements of the Act once it is fully implemented. Prior to the passage of the PPACA, a typical private health insurance policy only covered inpatient and outpatient treatment for mental illness.[93] However, a large number of effective mental health treatments did not qualify as inpatient or outpatient treatment. These included outpatient case management, psychosocial rehabilitation such as social skills training, vocational rehabilitation, and pharmacological treatment.[94] Most insurance

89. However, it is likely that the PPACA would force serious mental illnesses like bipolar disorder and major depression to receive the same coverage as medical illnesses like cancer or diabetes. *See* Barbara Mannino, *Mental Health Coverage Expanded Under PPACA*, FOX BUS. (Nov. 4, 2009), http://www.foxbusiness.com/personal-finance/2010/11/04/mental-health-coverage-expanded-ppaca/#. However, this Note argues that the expanded coverage for mental illnesses can and will be manipulated to make treatment for serious mental illnesses more expensive.

90. The levels of coverage are bronze, silver, gold, and platinum and would vary based on the level of benefits paid by the insurer. *See* 42 U.S.C. § 18022(d)(1)(A)-(D) (2006).

91. The Secretary of the Department of Health and Human Services would establish the level of benefits to be provided, but would base the determination on the standard level of care provided by the typical employer plan. 42 U.S.C. § 300gg-15 (2006).

92. These restrictions on certain treatments have been upheld by courts that determined that those treatments were not medically necessary and until overturned, courts may continue to exclude certain procedures on the same justifications. *See* discussion *supra* Part II.A.2. *See generally* U.S. DEPT' OF HEALTH & HUMAN SERV., OFFICE OF THE SURGEON GEN., *Mental Health: A Report of the Surgeon General, Financing and Managing Mental Health Care, History of Financing and the Roots of Inequality*, *available at* http://www.surgeongeneral.gov/library/mentalhealth/chapter6/sec3.html (last visited Oct. 3, 2011) [hereinafter *Mental Health*].

93. *See Mental Health, supra* note 92.

94. *Id.*

companies provided only a limited level of care due to the high costs arising from extended hospital stays, long-term care, and intensive psychotherapy.[95] Private insurance companies were also reluctant to provide services that were "guaranteed by the public mental health system" such as long-term, custodial hospital stays because those costs would be borne by the states.[96] Because the PPACA does not prohibit these insurance company behaviors, they are likely to continue to exclude some of these expensive treatments from the lower level coverage plans.

Similarly, individuals covered under a public insurance plan may find that some mental illnesses may not be covered. For example, the state insurance Exchanges require a benchmark level of coverage which expressly includes the "standard Blue Cross/Blue Shield preferred provider" plan and a typical HMO coverage plan.[97] The Exchanges, however, do not require coverage for inpatient treatment at an intermediate facility for the intellectually disabled.[98] Medicaid also has restrictions on the level of care provided to individuals receiving treatment at mental health institutions.[99] The net effect is that even though basic mental health coverage will be included in any insurance plan, more serious afflictions may be excluded or available only at a prohibitive cost. Thus, individuals with serious mental illnesses will receive incomplete mental health care, or no treatment at all.

C. Health Insurance that Covers Serious Mental Illnesses Would Still Be Expensive for the Average Individual Needing Coverage

Although the PPACA makes health insurance and, by extension, mental health coverage more accessible to individuals, the high costs associated with serious mental illnesses may make health insurance inaccessible to individuals with serious mental illness.[100] Initial indications show that health care costs will likely increase as a result of

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95. *Id.*

96. *Id.*

97. 42 U.S.C. § 1396u-7(b)(1) (2006).

98. *See id.* § 1396u-7(a)(2)(B)(v).

99. *See* 42 U.S.C. § 1396d(a)(29) (2006). The individuals may be covered if they are being treated at an intermediate care facility for the intellectually disabled that is not an institution for mental illness. *See id.* at § 1396d(a)(15).

100. A 2001 study showed that the cost of treating severe mental illness could reach as much as $125,000 per year for an individual. Alexander S. Young et al., *The Time Course of Treatment Costs Among Patients with Severe Mental Illness*, 52(1) PSYCHIATRIC SERVS. 21, 21 (2001) (discussing the treatment costs incurred by the Los Angeles County Department of Mental Health).

the Act.[101] These costs include premiums, deductibles, and out of pocket expenses. The insured may also have to bear non-monetary costs including easy access to mental health professionals and the availability of adequate facilities and treatment centers.[102]

Although the PPACA has provisions intended to keep insurance costs affordable, premiums that insurance companies charge must account for any increases in costs associated with providing benefits to individuals. There is a direct correlation between the costs of the benefits provided under a health insurance policy and the premiums charged to the policy holders.[103] In determining the costs of premiums, insurance companies must charge enough to cover any expected benefit payouts in addition to administrative costs, commission and marketing costs, taxes and fees, as well as allowances for operating profits.[104]

Adding to the overall cost of healthcare to insured individuals is the fact that there is no provision in the PPACA that prevents insurance companies from requiring referrals or pre-approval for specialty treatments like mental health.[105] Although certain treatments may be covered, the prerequisites put in place by the insurers may frustrate a number of individuals leading to under-treatment or the outright denial of treatment.[106] As a result, the monetary and non-monetary costs of receiving treatment for severe mental illness are likely to be high in comparison to other ailments.

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101. *See Report: Health Care Reform Will Increase Costs*, CBS NEWS (Apr. 23, 2010, 7:49 AM), http://www.cbsnews.com/stories/2010/04/23/politics/main6423757.shtml. *See also* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Harry Reid, Majority Leader, U.S. Senate 6 (Mar. 11, 2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf; MILLIMAN, INC., *2010 Milliman Medical Index* 7 (May 2010), *available at* http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2010.pdf [hereinafter "*Milliman Medical Index*"].

102. *See e.g.*, Shirley S. Wang, *Finding Referrals for Mental-Health Patients Often Elusive*, WALL ST. J. HEALTH BLOG (Apr. 14, 2009, 9:32 AM), http://blogs.wsj.com/health/2009/04/14/finding-referrals-for-mental-health-patients-often-elusive/.

103. *See generally* U.S. DEP'T OF HEALTH AND HUMAN SERV., CTR. FOR MEDICAID & MEDICARE SERV., *National Health Expenditure Projection: 2009-2019*, http://www.cms.gov/NationalHealthExpendData/downloads/proj2009.pdf (last visited Oct. 2, 2011); *Where Does a Premium Dollar Go?*, AM.'S HEALTH INS. PLANS COVERAGE, http://www.ahipcoverage.com/wp-content/uploads/2011/01/11.-Administrative-Cost-Slides.pdf (last visited Apr. 1, 2011).

104. *See e.g.*, *Key Issues in Analyzing Major Health Insurance Proposals*, CONG. BUDGET OFFICE 69 (Dec. 2008), http://www.cbo.gov/ftpdocs/99xx/doc9924/12-18-KeyIssues.pdf. *See also Milliman Medical Index*, *supra* note 101.

105. *See generally Mental Health*, *supra* note 92.

106. *See id.*

D. Individuals with Serious Mental Health Needs Would Likely Remain Uninsured

Even with the passage of the PPACA, an estimated twenty-three million individuals would still be unable to access affordable health coverage by 2019 when the PPACA is fully implemented.[107] Two main reasons why many people are not covered by employer-sponsored plans, the most commonly provided plans, are that they either do not have access to such plans or the costs are too prohibitive.[108] The cost of insurance is a major reason why individuals who are not insured under an employer-sponsored plan do not purchase individual plans.[109] Therefore, it is likely that a significant number of individuals with serious mental illnesses who typically have high health care costs will remain uninsured.

The situation is worse for individuals with serious mental illnesses that require hospitalization in a mental institution. Not only will many of them be unable to afford health insurance that covers their treatment, they also may not qualify for coverage under government-sponsored plans like Medicare, Medicaid, and the Exchanges. This is because individuals who are between the ages of twenty-one and sixty-five, but would otherwise qualify for Medicaid, may not be covered if they are patients in an institution for mental illness.[110] However, those individuals

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107. HENRY I. KAISER FAMILY FOUNDATION, *The Uninsured: A Primer, Key Facts About Americans Without Health Insurance*, KAISER COMM'N ON MEDICAID AND THE UNINSURED 14 (Dec. 22, 2010), http://www.kff.org/uninsured/upload/7451-06.pdf [Hereinafter *The Uninsured: A Primer*]. An estimated 4 million uninsured people would not qualify for an exemption based on their low income and will have to pay a penalty. *See 4M Estimated to Pay Health Care Penalty in 2016*, CBS NEWS (Apr. 23, 2010, 8:30 AM), http://www.cbsnews.com/stories/2010/04/22/politics/main6422023.shtml?tag=contentMain;contentBody.

108. *See The Uninsured: A Primer*, *supra* note 107, at 16-17. Other reasons why individuals are not covered by employer-sponsored plans include the fact that individuals have lost coverage because they became unemployed and could not afford to continue coverage; a decline in enrollment in employer-sponsored plans because of the recession; and low income of employees. *Id.* Also, individuals with serious mental disorders face higher levels of unemployment and, as a result, they are unlikely to have access to employer-sponsored insurance plans. *Id.*

109. *See id.* at 24.

110. *See* 42 U.S.C. § 1396d(a)(29)(B). This restriction may be a measure aimed at reducing mental health costs to the federal and state governments, the bulk of which are spent on skilled nursing facilities, intermediate care facilities, state psychiatric hospital care, and general hospital psychiatric care. State insurance exchanges have similar requirements that do not require coverage for inpatient treatment at an intermediate care facility for the mentally disabled. *See id.* § 1396u-7(a)(2)(B)(v). *See* Carl. A. Taube, et al., *Medicaid Coverage for Mental Illness: Balancing Access and Costs*, 9(1) HEALTH AFFAIRS 5, 6 (1990), *available at* http://content.healthaffairs.org/content/9/1/5.full.pdf.

may be covered if they are being treated at an intermediate care facility for the intellectually disabled that is not an institution for mental illness.[111] Many of these individuals who are left untreated typically end up homeless, institutionalized, or incarcerated.[112]

E. A More Comprehensive Program is Required to Ensure that Affordable Quality Health Care is Available for Individuals with Serious Mental Disabilities

One study estimates the cost of serious mental illness to the nation at $193.2 billion a year.[113] This figure does not include the costs of incarceration, homelessness, or the emotional and financial costs to family members.[114] As a result, the PPACA does not go far enough to address the problem of affordable health care coverage for mental illness, especially serious mental illness.

1. The PPACA Should Be Amended to Specifically Address How Mental Illness Should Be Covered

First, the PPACA should be amended to specifically define "mental illness." For instance, the PPACA could adopt the definition of mental illness used by respected professional organizations such as the American Psychiatric Association or the American Medical Association. Such an organization is in the best position to determine what constitutes a mental disorder based on its expertise. A universal definition of mental illness would resolve any ambiguity that may be exploited by insurance providers and would prevent them from declining coverage for illnesses based on their own definition of mental illness.

The PPACA should also be amended to enumerate the minimum level of mental health services that must be covered by all insurance plans. For example, legislation could be passed to build on the tiered coverage level established by the PPACA.[115] This could require progressively increasing levels of treatment for mental illnesses for the higher tier insurance coverage plans. Therefore, the "Bronze" level of coverage would cover basic services for mental health, and the

111. *See* 42 U.S.C. § 1396d(a)(15).

112. *See* Thomas R. Insel, *Assessing the Economic Costs of Serious Mental Illness*, 165(6) AM. J. PSYCHIATRY 663, 663 (2008).

113. *See id.*

114. *See id.* at 664.

115. *See* 42 U.S.C. § 18022(d)(1)(A)-(D).

"Platinum" level would provide full coverage for all mental health treatments.

The tiered system of benefits, however, would not apply to public insurance plans. Instead, individuals who qualify for insurance under a public health plan such as Medicaid would be fully covered for all treatments related to their mental illness. To accomplish this, the Medicaid Emergency Psychiatric Demonstration Project should be made permanent to provide emergency mental care for uninsured individuals at any emergency care center.[116] All these options would ensure that individuals unable to afford private insurance would be covered under a public plan for even the most serious mental illnesses.

2. Establishing a Funding Mechanism for Mental Illnesses at the State Level

Requiring that individuals who qualify for coverage under a public plan be fully covered would demand a funding mechanism to ensure that the states can afford these programs. Legislation that directly funds treatments for serious mental illness through existing programs like Medicare, Medicaid, and state-run insurance Exchanges must be passed. Although this may require an initial expenditure, in the long run, these costs may be offset by the savings realized from unburdening society of the costs associated with untreated mental illness.[117]

Direct funding for mental illness can be accomplished by amending the PPACA to expressly require states to spend a specific amount of their appropriations for the treatment of mental illnesses. Although all states provide some level of mental health coverage in their Medicaid programs, the coverage is discretionary.[118] As a result, funding levels for

116. The Project is currently scheduled to last for only three years. *See* Patient Protection and Affordable Care Act § 2707(d).

117. There is also an argument to be made that treating those with serious mental illness is a legal and moral imperative. *See, e.g.*, Michael L. Perlin, *"What's Good is Bad, What's Bad is Good, You'll Find Out When You Reach the Top, You're on the Bottom": Are the Americans with Disabilities Act (and Olmstead v. L.C.) Anything More Than "Idiot Wind?*, 35 U. MICH. J.L. REFORM 235, 245-47 (2002) (discussing whether the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.* has helped improve the way society deals with people with mental disabilities); Katie Eyer, *Litigating for Treatment: The Use of State Laws and Constitutions in Obtaining Treatment Rights for Individuals with Mental Illness*, 28 N.Y.U. REV. L. & SOC. CHANGE 1, 11-21 (2003) (discussing attempts at litigating for the right to treatment for the mentally ill).

118. *See* Smith et al., *supra* note 18, at 2.

mental health treatment by the states have been declining.[119] Therefore, states can be forced to increase their spending for the treatment of mental illness without any increase in the appropriations.

When viewed holistically, there would be little if any increase in the overall cost to the states. This is because the government ultimately bears the costs that arise from individuals who remain untreated for their severe mental illnesses.[120] When mental illnesses become severe enough, the afflicted end up either in the emergency room or in the correctional system, the costs of which the state eventually bears.[121] In addition, the cost of housing mentally ill inmates surpasses the cost of housing other inmates.[122] These costs are greater because of the need for medication, mental health staff, security, additional medical staff, potential damage to the facilities, and the cost of modifications to the facilities.[123] Therefore, taking steps to reduce the number of mentally ill persons in the correctional system would reduce the yearly costs each state spends in housing the mentally ill.

As a result of making these amendments to the current version of the PPACA, in the long run there would be a net decrease in the overall healthcare costs to the country as a whole. At the same time, the goal of the PPACA would be achieved by providing affordable mental health coverage, even for individuals with severe mental illnesses who would otherwise be unable to afford health coverage under the current version of the PPACA.

F. Criticisms of the PPACA

Some critics of the PPACA argue that provisions of the Act important to the overall success of the PPACA cannot be implemented within the framework of a private insurance system.[124] Specifically, they

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119. *See* Betty Ann Bowser & Lea Winerman, *State Budget Cuts Slash Mental Health Funding*, PBS NEWSHOUR (Jan. 17, 2011, 1:37 PM), http://www.pbs.org/newshour/rundown/2011/01/state-budget-cuts-slash-mental-health-funding.html.

120. *See generally* Insel, *supra* note 112.

121. Hospitals that participate in Medicare are required by law to treat any individual with a medical emergency until the individual is stabilized. *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(b) (2001). *See also* Alexander S. Young et al., *Characteristics of Individuals With Severe Mental Illness Who Use Emergency Services*, 41(2) CMTY. MENTAL HEALTH J. 159, 160 (2005).

122. *See* Nancy Deferrari, *Financial Impact of Housing the Mentally Ill*, 24(5) AM. JAILS 30, 31 (2010).

123. *See id.* at 38.

124. *See e.g.*, Richard A. Epstein, *Bleak Prospects: How Health Care Reform Has Failed in the United States*, 15 TEX. REV. L. & POL. 1 (2010); Mariner, *supra* note 84.

argue that the use of private health insurance exchanges would be unsuccessful because these exchanges cannot be profitable under the constraints of the PPACA.[125] These constraints include the requirement that private insurance exchanges must accept all patients, as well as restricting their ability to raise prices to cover their expenses.[126] It is argued that these provisions would doom the insurance exchanges to failure.[127] Accordingly, individuals with mental illnesses would be excluded from the most viable private insurance option available to them. However, the PPACA requires everyone to purchase health insurance and this requirement would help ensure that the pool of insured individuals would be large and diverse enough to make them cost-effective and profitable to the insurance carriers.

Critics also argue that the act impermissibly expands the size of government and perpetuates a welfare system that is fiscally unsustainable.[128] For example, there are a number of reports that suggest that because of ballooning benefit payouts, the Medicare and Medicaid systems are almost insolvent.[129] Therefore, once the Medicare and Medicaid systems inevitably become insolvent as a result of the expanded services required under the PPACA, states that administer programs like Medicaid would be forced to eliminate several services.[130] In that scenario, states are likely to cut mental health services first.[131] However, the PPACA specifically provides that specific services must be provided under Medicare and Medicaid.[132] Therefore, under the PPACA a more likely response to a financial crunch would be an increase in taxes or premiums rather than the elimination of health services.

In addition, one critic of the PPACA points to a provision within the statute that is aimed at "reducing the per capita growth rate of Medicare expenses," as evidence that it would also lead to substantial cuts to Medicare.[133] This would render the PPACA ineffective for current retirees who are dependent on Medicare.[134] By extension, these cuts

125. *See* Epstein, *supra* note 124, at 26-31.
126. *Id.*
127. *Id.*
128. *See e.g.*, *id.* at 32.
129. *See e.g.*, *id.*
130. *Id.* at 35.
131. Epstein, *supra* note 124, at 32-33.
132. 42 U.S.C. § 1395kkk (West 2011).
133. *Id.* § 1395kkk(b).
134. *See* Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 244 (2011). The commentator concludes by asking how the goal of reducing Medicare costs can be achieved without rationing health care to Medicare beneficiaries. *Id.* at 245.

would have a negative impact on individuals who rely on Medicare to cover their mental health costs. This argument ignores other provisions in the PPACA implemented to ensure the quality of health services the states provide remains high, regardless of any attempts to reduce costs.[135] The argument also discounts the fact that the government can achieve cost savings without affecting the quality of care. For example, policies intended to reduce administrative costs, or policies intended to take advantage of economies of scale as a result of the number of people on Medicare would reduce the per capita cost of Medicare without affecting the quality of services provided.[136]

IV. CONCLUSION

Congress enacted the PPACA to make quality, affordable health care available to all individuals, including those with mental illnesses.[137] The provisions of the PPACA make it difficult for health insurance providers to discriminate against those with mental illnesses.[138] As a result, the vast majority of individuals with mental illnesses would be covered under some form of private or public health insurance plan.[139] However, individuals with serious mental illnesses are likely to remain uninsured because of the prohibitive costs, which are a result of the ability of insurance providers to raise premiums for serious mental illnesses.[140]

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135. *See* 42 U.S.C. § 1395kkk(c)(2)(A) & (B).

136. There are real and significant issues not addressed in this Note that must be resolved before mental health services can actually be fully available to all individuals with mental illnesses. For example, the successful implementation of the PPACA depends on extensive state involvement which makes it susceptible to financial and political pressures. *See, e.g.*, Neil Krishan Aggarwal et al., *Is Health Care a Right or a Commodity? Implementing Mental Health Reform in a Recession*, 61(11) PSYCHIATRIC SERVICES 1144 (2010) (arguing that the PPACA contains contradictory elements that would make its implementation problematic). There are also many commentators that argue that the PPACA is needlessly intrusive, expensive, and ultimately ineffective. *See also, e.g.*, Robert M. Goldberg, *Obamacare Shreds Mental Health Care*, AM. SPECTATOR (Jan. 18, 2011, 6:06 AM), http://spectator.org/archives/2011/01/18/obamacare-shreds-mental-health; John Stossel, *The 3 Worst Obamacare Ingredients*, FOX BUS. BLOG (Mar. 22, 2010, 3:42 PM), http://www.foxbusiness.com/on-air/stossel/blog/2010/03/22/the-3-worst-obamacare-ingredients; John Cassidy, *Obamacare By The Numbers: Part 1*, THE NEW YORKER BLOG (Mar. 24, 2010), http://www.newyorker.com/online/blogs/johncassidy/2010/03/obamacare-by-the-numbers-part-1.html.

137. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

138. 42 U.S.C. § 300gg-5 (West 2011).

139. *See id.*; Patient Protection and Affordable Care Act, 124 Stat. 119.

140. *See* Young et al., *supra* note 100.

Accordingly, Congress needs to reform the PPACA to ensure that there is an , affordable health system for individuals with serious mental illnesses. Congress should achieve this goal by clearly defining what mental illnesses must be covered by private and public health care providers. In addition, a funding mechanism must be created to help provide care for individuals with serious mental illnesses who would otherwise be unable to afford coverage.

While the critics of the PPACA make valid points as to its shortcomings, these are shortcomings that can be overcome through changes that build on current provisions contained within the Act. As a result, a complete repeal of the PPACA would, at a minimum, reverse the progress that Congress has made in ensuring that individuals with mental illnesses have access to affordable mental health care free from discrimination based on their illnesses. The solutions suggested in this Note would not solve all of the country's mental health challenges, but they would lay a framework to effectively address them. Therefore, we could avoid future tragedies like the Tucson shooting involving individuals with untreated, serious mental illness because of the effective treatment avenues available to those individuals.

OLUKUNLE FADIPE