

THE FAILURE OF THE ADA — ACHIEVING PARITY
WITH RESPECT TO MENTAL AND PHYSICAL HEALTH
CARE COVERAGE IN THE PRIVATE
EMPLOYMENT REALM

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The business people have not been exposed to all of this legal terminology. You tell them 'mentally ill' and their word, and I'm going to say it in Spanish, is 'loco', crazy. 'We don't hire a loco. We don't hire a crazy person.' Any kind — it doesn't matter if it is a manic-depressive — the word there is loco. 'We've got a loco crazy working with us.' It is sad but that is the way it is.¹

INTRODUCTION

The Americans with Disabilities Act ("ADA") was enacted to "address the problem of discrimination against [disabled individuals] in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting and access to public services."² The Act should have provided a "clear and comprehensive national mandate for the *elimination of discrimination* against individuals with disabilities and to bring persons with disabilities into the *economic and social mainstream* of American life; to provide enforceable standards addressing discrimination against individuals with disabilities"³ The values that the ADA encompasses, such as "equal protection under the law, individual empowerment, freedom of association, [and] economic opportunity," are of crucial significance to all Americans.⁴ According to a "Questions and Answers" pamphlet released by the Equal Employment Opportunity

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¹ LAURA MANCUSO, PEOPLE WITH PSYCHIATRIC DISABILITIES, EMPLOYMENT, AND THE AMERICANS WITH DISABILITIES ACT: TURNING POLICY INTO PRACTICE 11 (1995) (emphasis added) (quoting Carlos Perez, a consumer advocate and businessman from South Texas).

² AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, 395 LAB. LAW REP. (CCH) ¶ 10, at 9 (July 31, 1990).

³ *Id.* (emphasis added).

⁴ NAT'L COUNCIL ON DISABILITY, THE AMERICANS WITH DISABILITIES ACT: ENSURING EQUAL ACCESS TO THE AMERICAN DREAM 6 (1995).

Commission ("EEOC") and the U.S. Department of Justice Civil Rights Division, the ADA "guarantees equal opportunity" for disabled individuals in fundamental areas of life like "public accommodations, employment, transportation, state and local government resources, and telecommunication."⁵ This note challenges the validity of that statement, specifically as it applies to the disparity between mental and physical health care benefits afforded employees in the private employment realm.

Part II provides important background on the ADA, including its origin and professed purpose as it relates to insurance coverage, and how the statute defines and how one can establish disability and discrimination. Part III offers a survey of the federal courts of appeals' respective rulings on whether the ADA mandates parity of coverage in the private employment realm. Part IV offers startling statistics and background information regarding mental illness. This Part emphasizes society's (and as made evident by Part III's survey, the federal courts' and government's) underestimation of the impact of mental illness on both the individual and society as a whole. In Part V this note proposes immediate legislative action demanding parity between insurance coverage for mental versus physical disabilities.

This crucial issue plagues millions of Americans each year. The ADA has clearly not lived up to its promise to "eliminate" discrimination and safeguard "equal opportunity" for the extraordinarily large portion of disabled Americans who live with mental illness. Discrimination against the mentally ill is as alive and well as ever, and, based on the legislative history and the federal courts' interpretations of the ADA, it appears that the ADA has actually sanctioned, and thereby encouraged, such discrimination. This note calls for new and immediate federal legislation that *actually does* what the ADA only purported to do — even the playing field between the disabled and nondisabled, and recognize mental illness for the legitimate, typically treatable, and widespread ailment that it is.

[A]lthough the ADA promises profound advances in the civil rights of people with disabilities, its practical application to the employment of people with psychiatric disabilities is frequently cited as one of the most poorly understood aspects of the law. A 1994 article in the Wall Street Journal predicted that 'protecting the mentally ill against discrimination may well prove to be the trickiest aspect of the controversial disabilities law.' Unless employers can determine how to comply successfully with

⁵ EQUAL EMPLOYMENT OPPORTUNITY COMM'N & U.S. DEP'T OF JUSTICE CIVIL RIGHTS DIV., THE AMERICANS WITH DISABILITIES ACT, QUESTIONS AND ANSWERS, Introduction (1996).

the ADA and feel motivated to do so, the law will have only a minimal effect on the lives of people with psychiatric disabilities.⁶

I. HISTORY AND PURPOSE OF THE ADA

A. BACKGROUND

The ADA protects an estimated 49 million disabled Americans.⁷ These individuals are substantially limited in their abilities to engage in activities like working, walking, talking, seeing, hearing, or caring for themselves, to name a few.⁸ As of 1986, the unemployment rate of disabled individuals averaged around 66 percent, while the unemployment rate of their non-disabled peers was, at most, only ten to fifteen percent.⁹ The disabled population's "high unemployment rate . . . is a drain on our national resources and represents an absence in our labor pool of the many individuals who want to contribute to our society,"¹⁰ not to mention the *personal* drain on the millions of Americans suffering in a stigma-friendly society.

Taking effect in July 1992,¹¹ Title I of the ADA specifies that an employer, employment agency, labor organization, or joint labor-management committee may not discriminate against any qualified individual with a disability in regard to any term, condition, or privilege of employment.¹² Prohibited discriminatory employment practices include those pertaining to "recruitment, advertising, tenure, layoff, leave . . . and all other employment-related activities."¹³ The anti-discrimination mandate also applies to "rates of pay or any other form of compensation and changes in compensation . . . [and] fringe benefits available by virtue of employment, whether or not administered by the [employer]."¹⁴ The ADA incorporates many of the standards of discrimination set out in regulations implementing section 504 of the Rehabilitation Act of 1973, including the obligation to provide reasonable accommodations unless it would result in an undue hardship on the operation of the business.¹⁵

⁶ MANCUSO, *supra* note 1, at vii.

⁷ NAT'L COUNCIL ON DISABILITY, *supra* note 4, at 31.

⁸ *Id.*

⁹ BRUCE S. GROWICK & PATRICK L. DUNN, THE AMERICANS WITH DISABILITIES ACT AND WORKERS' COMPENSATION: CRITICAL ISSUES AND MAJOR EFFECTS 2 (1995).

¹⁰ *Id.*

¹¹ MANCUSO, *supra* note 1, at 39.

¹² AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, *supra* note 2, ¶ 101, at 17.

¹³ EQUAL EMPLOYMENT OPPORTUNITY COMM. AND U.S. DEP'T OF JUSTICE CIVIL RIGHTS DIV., *supra* note 5, at 1.

¹⁴ AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, *supra* note 2, ¶ 102, at 27.

¹⁵ *See id.* Section 504 of the Rehabilitation Act covers "not only employment, but all federally funded activities. It commands that 'otherwise qualified' individuals with disabilities

B. DEFINING DISABILITY UNDER THE ADA

To establish a *prima facie* case of discrimination under Title I of the ADA, a plaintiff must prove: (1) that he or she is disabled, (2) that he or she is otherwise qualified to perform the essential functions of his or her job, with or without reasonable accommodation, and (3) that he or she has suffered adverse employment action because of his or her disability.¹⁶ The employer can defend itself against the plaintiff's claim with evidence that the reasonable accommodations appropriate to the employee's disability would impose an "undue hardship" on the employer's business.¹⁷

1. *Defining physical and mental impairment*

A physical or mental impairment is a disability if its severity results in a "substantial limitation" of one or more "major life activities."¹⁸

The EEOC has defined "substantially limits" to mean:

- (i) unable to perform a major life activity that the average person in the general population can perform; or
- (ii) significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner or duration under which the average person in the general population can perform that same major life activity.¹⁹

Determination of substantial limitation must take into account: (1) the nature and severity of the impairment, (2) its duration or anticipated duration, and (3) its long-term impact.²⁰

The EEOC and the Supreme Court have deemed "major life activities" to include "functions such as caring for oneself, performing manual

cannot 'be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency' or the postal service." *THE AMERICANS WITH DISABILITIES ACT MANUAL: STATE AND LOCAL GOVERNMENT SERVICES, EMPLOYMENT AND PUBLIC ACCOMMODATIONS* 102 (John Parry ed., 1992) (quoting 29 U.S.C. § 794(a)).

¹⁶ See *Heyman v. Queens Vill. Comm. for Mental Health for Jamaica Cmty. Adolescent Program, Inc.*, 198 F.3d 68 (2d Cir. 1999). See also *Ivy v. Jones*, 192 F.3d 514, 516 (5th Cir. 1999) (internal citation omitted); *Belk v. Southwestern Bell Tel. Co.*, 194 F.3d 946, 949-950 (8th Cir. 1999); *Sorensen v. Univ. of Utah Hosp.*, 194 F.3d 1084, 1086 (10th Cir. 1999), *Doe v. Dekalb County Sch. Dist.*, 145 F.3d 1441, 1445 (11th Cir. 1998).

¹⁷ 42 U.S.C. § 12112(b)(5)(A) (2000).

¹⁸ 42 U.S.C. § 12102(2)(A) (2000). The ADA additionally defines "disability" as "a record of such an impairment [that substantially limits one or more major life activities]" or "being regarded as having such an impairment." 42 U.S.C. § 12102(2) (2000).

¹⁹ 29 C.F.R. § 1630.2(j)(1) (2000).

²⁰ See *id.* § 1630.2(j)(2)(i)-(iii).

tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”²¹ The Ninth Circuit, in deciding a case involving a man suffering from anxiety and panic disorders, has recently added “sleeping, engaging in sexual relations, and interacting with others” to the list,²² and the Eighth Circuit has added “[s]itting, standing, lifting and reaching.”²³ In other words, the list of activities set forth in EEOC regulations are not exhaustive, but rather illustrative.²⁴

A substantial limitation of the major life activity of working is evident when one is “significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills, and abilities.”²⁵ Hence, one’s inability to perform a single job does not constitute a substantial limitation.²⁶

In ADA terms, “mental disability” encompasses both mental illnesses and developmental disabilities.²⁷ Since there is much overlap in the types of illnesses in each of the categories, they are not entirely separable.²⁸ The ADA Manual defines “[m]ental illness [as] a group of illnesses, including both mental and cognitive disorders, while *developmental disabilities* are a variety of conditions grouped by their severity and age of onset.”²⁹ Development disabilities include “physical, cognitive, and mental illnesses that begin by early adulthood, are likely to continue indefinitely, and produce a severe functional impairment, in that they adversely affect one or more of the individual’s major life activities.”³⁰ More specifically, “[i]ndividuals with psychiatric diagnoses such as major depression, bipolar disorder, and schizophrenia may be covered under the ADA, depending on how the condition affects their functioning.”³¹ “Individuals with other psychiatric conditions (such as

²¹ 29 C.F.R. § 1630.2(i); *Bragdon v. Abbott*, 524 U.S. 624, 638–39 (1998) (quoting 45 C.F.R. § 84.3(j)(2)(ii) (1997) and 28 C.F.R. § 4131(b)(2) (1997)).

²² *McAlindin v. County of San Diego*, 192 F.3d 1226, 1230 (9th Cir. 1999).

²³ *Fjellestad v. Pizza Hut of America, Inc.*, 188 F.3d 944, 948 (8th Cir. 1999).

²⁴ See *Bragdon v. Abbott*, 118 S. Ct. 2196, 2205 (1998).

²⁵ DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, EXPLANATION OF THE CONTENTS OF THE AMERICANS WITH DISABILITIES ACT 13 (1994); see also *Sutton v. United Air Lines*, 119 S. Ct. 2139, 2151 (1999) (ruling that with respect to the major life activity of working, the plaintiff-employee must be “unable to work in a broad class of jobs”).

²⁶ DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, *supra* note 25, at 13; see also *Sutton*, 527 U.S. at 491.

²⁷ DEBORAH ZUCKERMAN & JOHN PARRY, *Disability Definition and Terms*, in THE AMERICANS WITH DISABILITIES ACT MANUAL, *supra* note 15, at 97, 97.

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

³¹ CORNELL UNIV., EMPLOYING AND ACCOMMODATING WORKERS WITH PSYCHIATRIC DISABILITIES 1 (1994).

anxiety, personality, dissociative, or post-traumatic stress disorders) may also be included" under the ADA's "mental disability" umbrella.³²

2. *Establishing physical or mental impairment under the law*

The United States Supreme Court has held that the availability of mitigation or correction is crucial in determining whether a person has a disability under the ADA.³³ In making this determination, a court should not evaluate persons in their "hypothetical uncorrected state," but rather with reference to the corrective measures available to them, such as medications, auxiliary aids and reasonable accommodations.³⁴

This recent addition to the body of case law on the subject may have serious implications for those suffering from mental illness. For instance, the Eighth Circuit recently cited these Supreme Court cases in deciding an ADA case involving depression.³⁵ The court stated: "[A] determination of whether [the plaintiff-employee's] depression is a disability must be made with reference to any mitigating measures he employs. 'A person whose physical or mental impairment is corrected by medication or other measures does not have an impairment that presently 'substantially limits' a major life activity.'"³⁶ However, "the mere use of a corrective device alone is not enough to relieve an individual of a disability; rather, 'one has a disability . . . if, notwithstanding the use of a corrective device, that individual is substantially limited in a major life activity.'"³⁷

A "qualified individual" under the ADA, is a person who "with or without reasonable accommodation can perform the essential functions of the employment position that such individual holds or desires."³⁸ This analysis involves a two-pronged inquiry. First, the individual must have the "requisite skill, experience, education and other job-related requirements of the employment position that such individual holds or desires."³⁹ Second, the individual must be able to "perform the essential functions of the position held or sought with or without reasonable accommodation."⁴⁰

³² *Id.*

³³ *See* Sutton, 527 U.S. at 480.

³⁴ *See id.* at 480; *see also* Murphy v. UPS, 527 U.S. 516, 520 (1999); Higgins v. New Balance Athletic Shoe, Inc., 194 F.3d 252, 265 (1st Cir. 1999); Ivy v. Jones, 192 F.3d 514, 516 (5th Cir. 1999).

³⁵ Spades v. City of Walnut Ridge, 186 F.3d 897 (8th Cir. 1999).

³⁶ *Id.* at 900 (citing Sutton, 527 U.S. at 481-83) (internal citation omitted).

³⁷ Belk v. Southwestern Bell Tel. Co., 194 F.3d 946, 950 (8th Cir. 1999) (citing Sutton, 527 U.S. at 488).

³⁸ 42 U.S.C. § 12111(8) (1995).

³⁹ Deane v. Pocono Med. Ctr., 142 F.3d 138, 145 (3d Cir. 1998) (citing 29 C.F.R. § 1630.2(m) (2000)).

⁴⁰ *Id.* at 145.

Under the ADA, an employer "discriminates" if it does not make "reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability" ⁴¹ The employer is liable for discrimination under the ADA for its failure to accommodate the employee's limitations if such limitations affect the "terms, conditions or privileges" of the employee's employment. ⁴² Clearly then, the "reasonable accommodation" component of the ADA's assurance of nondiscrimination is a critical one.

An employer makes a "[r]easonable accommodation . . . [by making] any change in the work environment or in the way things are usually done that results in equal employment opportunity for an individual with a disability." ⁴³ Courts have held that an employer has a duty to make reasonable accommodations with respect to *all* employment decisions, not simply those decisions regarding hiring and promotion. ⁴⁴ Reasonable accommodations "should be tailored to the needs of the individual and the requirements of the job" ⁴⁵ and include "modifications or adjustments that enable an employee with a disability to enjoy *equal benefits and privileges* of employment as are enjoyed by other similarly situated employees without disabilities." ⁴⁶

In particular, reasonable accommodations may include "job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations." ⁴⁷ In sum, an employer that knows about an employee's disability but still fails to provide reasonable accommodations violates the ADA. ⁴⁸ This is true regardless of the employer's intent. ⁴⁹ In other words, an employer, in failing to provide a reasonable accommodation, need not be "motivated by a discriminatory animus directed at the disability" in order to violate the statute. ⁵⁰

⁴¹ 42 U.S.C. § 12112(b)(5)(A) (1995).

⁴² *Higgins*, 194 F.3d at 264.

⁴³ SUSANNE M. BRUYERE & GWEN THAYER HANDELMAN, *HEALTH BENEFIT PLANS AND THE ADA, A TRAINER'S GUIDE* 8 (1995).

⁴⁴ See EQUAL EMPLOYMENT OPPORTUNITY COMM'N & U.S. DEP'T OF JUSTICE CIVIL RIGHTS DIV., *supra* note 5.

⁴⁵ AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, *supra* note 2, ¶ 101, at 22.

⁴⁶ DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, *supra* note 25, at 22 (emphasis added).

⁴⁷ 42 U.S.C. § 12111(9)(B).

⁴⁸ See *Higgins*, 194 F.3d at 264.

⁴⁹ See *id.*

⁵⁰ *Id.*

In making reasonable accommodations for an employee's physical or mental disability, proof of undue hardship on the operation of the employer's business is a defense to a plaintiff's claim under the ADA.⁵¹ The government has defined "[u]ndue hardship [as] an action requiring significant difficulty or expense, i.e., an action that is unduly costly, extensive, substantial, disruptive, or that will fundamentally alter the nature of the program."⁵² A determination of undue hardship must account for several factors, such as the nature and net cost of the accommodation, the overall financial resources of the facility and the covered entity, the type of operation of the covered entity, and the impact of the accommodation upon the operation of the facility.⁵³

C. THE ADA'S PROVISIONS REGARDING HEALTH INSURANCE COVERAGE

1. *The ADA's provisions*

Since the ADA's inception, covered entities have made great strides in implementing the Act's employment provisions, thereby removing formal barriers to the employment of the disabled.⁵⁴ However, many barriers still exist. For instance, the ADA does not mandate that employers provide health insurance that will cover *all* of the medical conditions of their employees.⁵⁵

Instead, the ADA has a "safe-harbor" provision, disallowing one from construing Titles I through III "to prohibit or restrict an insurer from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law," unless the prohibition or restriction is "a subterfuge to evade the purposes" of Titles I or III.⁵⁶

Courts have interpreted the subterfuge clause quite liberally, often ruling in favor of insurance companies. They have held that a litigant must demonstrate the insurer had "an intent to evade" before finding the insurer engaged in subterfuge to evade the purposes of Titles I and III of the ADA.⁵⁷ Some courts have gone so far as to rule that underwriters

⁵¹ See 42 U.S.C. § 12112(b)(5)(A); see also *Higgins*, 194 F.3d at 41.

⁵² AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, *supra* note 2, ¶ 101, at 24.

⁵³ See *Growick & Dunn*, *supra* note 9, at 20.

⁵⁴ See NAT'L COUNCIL ON DISABILITY, *supra* note 4, at 7.

⁵⁵ See *Growick & Dunn*, *supra* note 9, at 20 (emphasis added).

⁵⁶ 42 U.S.C. § 12201(c)(1).

⁵⁷ See, e.g., *Leonard F. v. Israel Disc. Bank of N.Y.*, 199 F.3d 99, 104 (2d Cir. 1999).

need not have based their decision with respect to disability coverage on "sound actuarial principles."⁵⁸

An employer cannot "*completely* deny health insurance coverage to an [employee] based on [his/her] diagnosis or disability."⁵⁹ While an employer may offer insurance policies that "limit coverage for certain procedures or treatments, *e.g.*, only a specified amount per year for mental health coverage,"⁶⁰ an employer cannot deny coverage to a mentally ill person for other conditions "such as for a broken leg or for heart surgery because of the existence of the mental health condition"⁶¹ Any limitations imposed on insurance coverage" must apply to persons with or without disabilities."⁶²

In other words, employers may reduce opportunities or benefits to all employees or categories of employees,⁶³ even though such limitations will disproportionately affect disabled persons,⁶⁴ as long as such reductions are not made for "discriminatory reasons."⁶⁵ For instance, an employer's leave policy if "uniformly applied . . . does not violate the ADA [by mere virtue of its having] a more severe effect on an individual because of his/her disability."⁶⁶ But "if an individual with a disability requests a modification of such a policy as a reasonable accommodation, an employer may be required to provide it, unless it would impose an undue hardship."⁶⁷

The ADA also defines discrimination as "[p]articipating in a contractual or other arrangement that has the effect of subjecting a qualified applicant or employee with a disability to the discrimination prohibited

⁵⁸ *Id.* at 18; *see also* *Doe v. Mut. of Omaha Ins. Co.*, 179 F.3d 557, 564 (7th Cir. 1999) ("It is one thing to say that an insurance company may not refuse to deal with disabled persons; the prohibition of such refusals can probably be administered with relatively little interference with state insurance regulation It is another thing to require federal courts to determine whether limitations on coverage are actuarially sound"); *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612 (3d Cir. 1998) (opining that construing § 501(c) to mandate underwriting based on sound actuarial principles would "require insurers to justify their coverage plans in [federal] court after a mere allegation by a plaintiff," thereby effecting a "seismic shift in the insurance business").

⁵⁹ AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, *supra* note 2, ¶ 102, at 28.

⁶⁰ Interestingly, this text only targets mental health coverage as an example of a permissible limitation.

⁶¹ AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, *supra* note 2, ¶ 102, at 28.

⁶² *Id.*

⁶³ *See* Zuckerman & Parry, *supra* note 27, at 29.

⁶⁴ WORKERS COMP. RESEARCH INST., THE AMERICANS WITH DISABILITIES ACT, IMPLICATIONS FOR WORKERS' COMPENSATION 89 (Stacey Eccleston ed., 1992).

⁶⁵ *See* THE AMERICANS WITH DISABILITIES ACT MANUAL: STATE AND LOCAL GOVERNMENT SERVICES, EMPLOYMENT AND PUBLIC ACCOMMODATIONS, *supra* note 15, at 29.

⁶⁶ *See* EQUAL EMPLOYMENT OPPORTUNITY COMM'N AND U.S. DEP'T OF JUSTICE CIVIL RIGHTS DIV., *supra* note 5, at 9.

⁶⁷ *See id.*

by . . . Title [I].”⁶⁸ Such an arrangement includes an employer’s “relationship with . . . an organization providing fringe benefits to an employee of the covered entity”⁶⁹ For purposes of the present discussion, such a contractual arrangement would be that between the private employer and its insurance carrier, through which the employer offers its employees health insurance benefits.

2. *Courts’ interpretations of the ADA’s mandate*

Some of the above propositions were put to work⁷⁰ in a recent court of appeals decision. In *Doe v. Mutual of Omaha Insurance Co.*, the Seventh Circuit upheld an insurance cap for AIDS patients even though the insurance company could not show that the cap was “consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law.”⁷¹ The court reasoned that, although the cap concededly made the insurance policy less valuable to people with AIDS, the insurer had not violated the ADA by imposing such a cap because the insurance policy provided persons with AIDS the same medical benefits as it did persons without AIDS, in terms of non-AIDS related medical needs.⁷²

In a startling attempt at analogy, the court likened the AIDS patient’s claim to that of a one-legged person complaining of a shoe store’s refusal to sell shoes other than by the pair.⁷³ The court distinguished the plaintiff’s claim from a hypothetical case of an insurance plan’s refusal to provide the same coverage for a broken leg, or other afflictions not peculiar to people with AIDS.⁷⁴ The court stated that such a hypothetical case would be “a good example of discrimination by reason of disability.”⁷⁵ Finally, the court stated:

There is, as we have pointed out, a difference between refusing to sell a health-insurance policy at all to a person with AIDS, or charging him a higher price for such a policy, or attaching a condition obviously designed to deter people with AIDS from buying the policy (such as refusing to cover such a person with a broken leg), on the one hand, and, on the other, offering insur-

⁶⁸ AMERICANS WITH DISABILITIES ACT OF 1990: LAW AND EXPLANATION, *supra* note 2, ¶ 102, at 28.

⁶⁹ *Id.* at 28–29.

⁷⁰ Though not in the private employment realm, but rather in a scenario involving an insurance policy purchased directly from the insurer.

⁷¹ *Doe*, 179 F.3d at 558.

⁷² *See id.* at 559.

⁷³ *Id.*

⁷⁴ *Id.* at 561.

⁷⁵ *Id.*

ance policies that contain caps for various diseases some of which may also be disabilities within the meaning of the [ADA].⁷⁶

However, in a case from the Northern District of Georgia with similar facts, the court invalidated an insurance company's cap on lifetime benefits for AIDS treatment.⁷⁷ The court found that "insurance practices are protected to the extent they are in accord with sound actuarial principles, reasonably anticipated experience, or bona fide risk classification."⁷⁸ Finding that the insurance company had not met its burden of proof regarding the basis for its risk classification, the court went so far as to postulate that "the underwriting risks associated with the treatment of AIDS cannot be so different from the treatment of innumerable other disabilities"⁷⁹

Perhaps more relevant to the issue currently at hand, the Court of Appeals for the Second Circuit recently addressed the issue of whether a private insurance company discriminated against an individual on the basis of his mental disability "in violation of Title III of the [ADA] by contracting with his employer . . . to provide him with a health insurance policy that limited coverage for mental disabilities to two years while providing coverage for physical disabilities that was not so limited."⁸⁰ The court ultimately decided that a policy consistent with state law and adopted prior to the ADA is "exempt from regulation under the [ADA] pursuant to the safe harbor provision of Section 501(c), regardless whether it was based on actuarial experience."⁸¹ Since Congress had not yet adopted the ADA, it was impossible for the policy to be the product of an evasion of the ADA — a "subterfuge."⁸²

The United States District Court for the Northern District of California recently found that Title III is applicable to insurance underwriting

⁷⁶ *Id.* at 563.

⁷⁷ *World Ins. Co. v. Branch*, 966 F. Supp. 1203 (N.D. Ga. 1997). It should be noted that, upon appeal, the Eleventh Circuit vacated that part of the district court's decision regarding AIDS and Title III on the grounds of mootness after the lower court rescinded the policy. *See World Ins. Co. v. Branch*, 156 F.3d 1142 (11th Cir. 1998).

⁷⁸ *Branch*, 988 F.Supp. at 1208.

⁷⁹ *Id.* at 1209.

⁸⁰ *Leonard F.*, 199 F.3d at 100 (citation omitted).

Title III of the ADA, which generally prohibits discrimination on the basis of disability by so-called 'public accommodations,' provides in Section 302(a): 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.

Id. at 101, quoting 42 U.S.C. § 12182(a).

⁸¹ *Id.* at 104-05.

⁸² *Id.* at 106.

practices.⁸³ The court explained that “[i]f Title III were meant only to prevent insurance companies from denying persons with disabilities equal access to the physical plants of insurance offices, there would have been no need for Congress to include the safe harbor provision dealing with underwriting practices.”⁸⁴

The court supported its ruling by pointing to the legislative history of Title III. In particular, the court cited a House Report which stated that an insurer could not charge an individual a different rate for insurance coverage solely because of a physical or mental impairment, “except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience” that certain conditions require some level of extraordinary expense.⁸⁵ The court also pointed to another substantially similar House Report in support of its conclusion.⁸⁶ The opinion continued to recognize that the exercise of significant discretion on the part of underwriters in setting insurance rates according to risk classifications presents the potential for disability-based discrimination.⁸⁷ Therefore, the basis of such insurance rates must rest on sound actuarial principles.⁸⁸

Obviously, there is substantial disagreement among the circuit courts of appeal regarding Title III’s role in policing the insurance industry. As made evident in Part III of this note, there is considerably less disagreement among the federal courts regarding the application of Title I to the regulation of insurance policies provided in the private employment realm.

A recently conducted telephone survey collaboratively administered by the Society for Human Resource Management, Cornell University, the Washington Business Group on Health, and the Lewin Group revealed that “more than nine out of ten respondent[-employers] said that no wage dispute (ninety-four percent), denied or reduced benefits (ninety-three percent), or failure to rehire (ninety-two percent) claims had been brought against their organizations under the ADA.”⁸⁹

The same survey revealed that accommodations made for employees with disabilities included: (1) the making of existing facilities acces-

⁸³ Chabner v. United Omaha Life Ins. Co., 994 F. Supp. 1185, 1190 (N.D. Cal. 1998).

⁸⁴ *Id.* at 1190–91.

⁸⁵ *Id.* at 1191 (quoting 1990 U.S.C.C.A.N. 267, 420).

⁸⁶ *Id.* (quoting 1990 U.S.C.C.A.N. 267, 493, which states that the safe harbor provision “makes it clear that insurers may continue to sell to and underwrite individuals applying for life, health, or other insurance on an individually underwritten basis, or to service such insurance products, so long as the standards used are based on sound actuarial data and not speculation”) (alteration in original).

⁸⁷ *See id.* at 1194.

⁸⁸ *See id.*

⁸⁹ SOC’Y FOR HUMAN RES. MGMT, THE ADA AT WORK: IMPLEMENTATION OF THE EMPLOYMENT PROVISIONS OF THE AMERICANS WITH DISABILITIES ACT 5 (1999).

sible to employees with disabilities, (2) being flexible in its application of human resources policies, (3) the restructuring of jobs or the modification of work hours, (4) making parking or transportation accommodations, (5) the provision of written job instructions, (6) the modification of the work environment, (7) the acquisition or modification of equipment or devices, (8) reassignments to vacant positions, (9) the changing of supervisory methods, (10) the provision of qualified readers or interpreters, and (11) the acquisition or modification of examination or training materials.⁹⁰

The majority of respondents, however, admitted to not having made any changes to health and other benefits as a direct response to the ADA.⁹¹ More specifically, approximately eight out of ten organizations interviewed made no changes to their long-term disability (seventy-eight percent), health insurance (seventy-seven percent) or short-term disability policies (seventy-seven percent) as a direct result of the ADA.⁹²

II. COURTS OF APPEALS' TREATMENT OF HEALTH INSURANCE COVERAGE FOR MENTAL VS. PHYSICAL ILLNESS

A survey of the federal circuit courts reveals that, to date, eight courts of appeal have directly addressed the issue of mental versus physical health insurance disparities as they relate to the ADA.⁹³ All eight circuits have conclusively determined that the ADA does *not* mandate parity between mental and physical disability benefits.

In *Ford v. Schering-Plough Corp.*, the Third Circuit directly addressed the issue of "whether a disparity between disability benefits for mental and physical disabilities violates the [ADA]".⁹⁴ The plaintiff, an employee disabled by a mental disorder and unable to continue her employment, filed suit against her employer and its insurance carrier for having implemented a two-year cap on mental disability benefits, but not on physical disability benefits.⁹⁵ More specifically, mental disability benefits were capped at two years unless the disabled individual was hospitalized, whereas physical disability benefits promised to continue as needed until the disabled individual reached the age of sixty-five.⁹⁶

⁹⁰ *Id.* at 6.

⁹¹ *See id.* at 8.

⁹² *Id.*

⁹³ These circuits include the Third, Fourth, Sixth, Seventh, Eighth, Ninth, Tenth, and the District of Columbia.

⁹⁴ 145 F.3d 601 (3d Cir. 1998).

⁹⁵ *Id.* at 603-04.

⁹⁶ *Id.* at 604.

Finding that neither the ADA nor subsequent legislation contained parity requirements for mental and physical disability benefits,⁹⁷ the court held: "So long as every employee is offered the same plan regardless of that employee's contemporary or future disability status, then no discrimination has occurred even if the plan offers different coverage for various disabilities."⁹⁸ The court further opined: "The ADA does not require equal coverage for every type of disability; such a requirement, if it existed, would destabilize the insurance industry in a manner definitely not intended by Congress when passing the ADA."⁹⁹

The Fourth Circuit addressed the issue of "whether Title II of the [ADA] requires a state's long-term disability plan to provide equal benefits for mental and physical disabilities" in *Rogers v. Department of Health and Environmental Control*.¹⁰⁰ In *Rogers*, a state employee was covered by a long-term disability plan that provided one year of benefits for mental disabilities and benefits to age 65 for physical disabilities.¹⁰¹ The plaintiff was diagnosed with a panic-anxiety disorder and received disability benefits for one year.¹⁰² "The plaintiff sued his employer after the year's end, alleging that (1) he was discriminated against because he was denied the same level of benefits as someone with a physical disability, and (2) the plan's lower benefit level for mental disability was not based on proper risk classification because the separate classification for mental disability lacked a sound actuarial basis."¹⁰³

The *Rogers* court held that the ADA neither requires equal benefits for mental and physical disabilities,¹⁰⁴ nor mandates that the plan sponsors justify risk classifications with actuarial data.¹⁰⁵ The court based its holding in part on House and Senate Committee interpretations of the ADA: the relevant Committee Reports state that "[t]he Committee . . . wishes to clarify that in its view . . . employee benefit plans should not be found to be in violation of this legislation under impact analysis simply because they do not address the special needs of every person with a disability, e.g., additional sick leave or medical coverage."¹⁰⁶ The court also looked to the EEOC's "interim policy guidance" on the application of the ADA to health insurance, which states that employer-provided

⁹⁷ *Id.* at 610.

⁹⁸ *Id.* at 608.

⁹⁹ *Id.*

¹⁰⁰ 174 F.3d 431, 432 (4th Cir. 1999). Though this note primarily addresses Title I of the ADA, the court's reasoning with respect to the ADA, in general, is helpful in this analysis.

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 436.

¹⁰⁵ *Id.* at 437.

¹⁰⁶ *Id.* at 434 (citing S. Rep. 101-116, at 85 (1989); H.R. Rep. 101-485, at 137 (1990), reprinted in 1990 U.S.C.C.A.N. 267, 420).

health insurance plans that distinguish between the benefits provided for the treatment of physical and mental conditions do not violate the ADA.¹⁰⁷

More recently the Fourth Circuit decided the same issue, but with respect to Title I and the private employment realm.¹⁰⁸ Like the *Rogers* court, the court in *Lewis* ruled that Title I of the ADA does not require a long-term disability plan sponsored by a private employer to provide the same level of benefits for mental and physical disabilities.¹⁰⁹ In this case, the plaintiff-employee was covered under his employer's long-term disability plan which capped mental disability benefits at two years but only capped physical disability benefits upon a participant turning age sixty-five.¹¹⁰ The plaintiff, who received disability benefits while on disability leave for severe depression, filed suit against his employer, alleging that he had been subjected to discrimination on the basis of his mental disability because he was given less disability insurance coverage than a person with a physical disability.¹¹¹ The Fourth Circuit reversed the district court's holding,¹¹² finding no material distinction between Titles I and II of the ADA, and therefore relying on the same reasoning it applied in *Rogers*.¹¹³

In *Parker v. Metropolitan Life Insurance Co.*, the Sixth Circuit ruled on the issue of "whether Title III of the ADA prohibits an employer from providing . . . a long-term disability plan issued by an insurance company which contains longer benefits for employees who become disabled due to a physical illness than for those who become disabled due to a mental illness."¹¹⁴ In this case, the plaintiff-employee, who suffered from severe depression, challenged her employer's long-term disability plan which capped mental disability benefits at twenty-four months unless hospitalization was involved, but provided physical disability benefits to age sixty-five.¹¹⁵ "The court found that the ADA prohibits only

¹⁰⁷ *Id.* at 435 (citing EEOC: INTERIM GUIDANCE ON APPLICATION OF ADA TO HEALTH INSURANCE (June 8, 1993), reprinted in Fair Empl. Prac. Man. (BNA) 405:7115, 7118).

¹⁰⁸ *Lewis v. Kmart Corp.*, 180 F.3d 166 (4th Cir. 1999).

¹⁰⁹ *Id.* at 168.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.* at 172.

¹¹³ *Id.* at 170. "Title II of the ADA applies to 'public entities,' which include states and their departments and agencies." *Rogers*, 174 F.3d at 433, citing 42 U.S.C. § 12131. "The substance of Title II is that 'no qualified individual with a disability shall, by reason of such disability, [1] be excluded from participation in or denied the benefits of the services, programs, or activities of a public entity, or [2] be subjected to discrimination by any such entity.'" *Rogers*, 174 F.3d at 433, quoting 42 U.S.C. § 12132 (emphasis added).

¹¹⁴ 121 F.3d 1006, 1008 (6th Cir. 1997).

¹¹⁵ *Id.*

discrimination between the disabled and the non-disabled, and does not mandate equality between individuals with different disabilities.”¹¹⁶

In *EEOC v. CNA Insurance Cos.*, the Seventh Circuit addressed the issue of “to what extent, if at all, the [ADA] requires equality of treatment among disabilities in benefit plans.”¹¹⁷ A CNA employee, who suffered from severe depression and bipolar illness, participated in her employer’s disability plan which capped mental disability benefits at two years but provided physical disability benefits to age 65.¹¹⁸ “The EEOC filed suit against CNA on behalf of the employee, alleging that CNA’s long-term disability plan discriminated against employees with mental or nervous disorders, in violation of the ADA.”¹¹⁹ Finding in favor of the defendant-employer, the court noted:

[T]here is no claim here that CNA discriminated on the basis of disability in offering its pension plan to anyone. It did not charge higher prices to disabled people, on the theory that they might require more in benefits Nor did it vary the terms of its plan depending on whether or not the employee was disabled. All employees — the perfectly healthy, the physically disabled, and the mentally disabled — had a plan that promised them long-term benefits from the onset of disability until age 65 if their problem was physical, and long-term benefits for two years if the problem was mental or nervous. This may or may not be an enlightened way to do things, but it was not discriminatory in the usual sense of the term.¹²⁰

The court held that it would not support a claim for parity “[w]ithout far stronger language in the ADA supporting” such.¹²¹ The court went on to state that mental health advocates have long been disappointed in the narrow scope of the ADA, as “well-illustrated by the debate over a proposed amendment to the Health Insurance Portability and Accountability Act of 1996.”¹²² The proposed amendment, which was ultimately defeated, would have mandated parity of coverage for mental and physical conditions.¹²³ The court reasoned: “This debate reinforces our conclusion based on the language of the ADA that the issue of parity

¹¹⁶ *Id.* at 1015.

¹¹⁷ 96 F.3d 1039, 1041 (7th Cir. 1996).

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.* at 1044-45 (internal citations omitted).

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.* at 1044.

among physical and mental health benefits is one that is still in the legislative arena.”¹²⁴ Ultimately, the court held that CNA’s long-term disability plan’s distinction between mental health benefits and other benefits did not violate Title I of the ADA.¹²⁵

In *Krauel v. Iowa Methodist Medical Center*,¹²⁶ the Eighth Circuit addressed the general issue of discrimination under the ADA as it pertained to a private employer’s medical benefits plan that excluded coverage for treatment of infertility problems. In upholding the district court’s grant of summary judgment for the employer, the court likened the plan’s limitation to that contained in many employer benefit plans which draw distinctions between physical and mental health care coverage.¹²⁷ The court stated:

Insurance distinctions that apply equally to all insured employees, that is, to individuals with disabilities and to those who are not disabled, do not discriminate on the basis of disability Such broad distinctions which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of disability and do not violate the ADA.¹²⁸

The Ninth Circuit recently addressed the issue of “whether an employer and its insurance administrator can offer a group disability insurance policy . . . that gives more benefits for physical disabilities than for mental disabilities, without violating the [ADA]”¹²⁹ The plaintiff-employee was covered under her employer’s long-term disability insurance policy, which capped mental disability benefits at twenty-four months yet provided physical disability benefits to age sixty-five.¹³⁰ The plaintiff, who suffered from severe depression, filed suit under Titles I and II of the ADA against her employer and its insurance carrier when her mental disability benefits ceased after the twenty-four-month period.¹³¹

¹²⁴ *Id.*

¹²⁵ *Id.* at 1045.

¹²⁶ 95 F.3d 674 (8th Cir. 1996).

¹²⁷ *See id.* at 678.

¹²⁸ *Id.* (citing EEOC: INTERIM ENFORCEMENT GUIDANCE ON APPLICATION OF ADA TO HEALTH INSURANCE (June 8, 1993), *reprinted in* Fair. Empl. Prac. Man. (BNA) 405:7115, 7118).

¹²⁹ *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1107 (9th Cir. 2000).

¹³⁰ *Id.* at 1107–08.

¹³¹ *Id.* at 1108.

The court stated that "there is no discrimination under the [ADA] where disabled individuals are given the same opportunity as everyone else, so insurance distinctions that apply equally to all employees cannot be discriminatory."¹³² The court supported its decision by noting that "[i]nsurers have historically and consistently made distinctions between mental and physical illness in offering health and disability coverage."¹³³ The court further explained:

Since the passage of the [ADA], Congress passed the Mental Health Parity Act, which requires that health plans with no limit for medical benefits must also have no limit on mental health benefits. Congress rejected an amendment to the Health Insurance Portability and Accountability Act of 1996 that would have required parity in insurance coverage for mental and physical illnesses. Had Congress provided that the Act means what Weyer . . . urge[s], then this subsequent legislation would have been superfluous.¹³⁴

The Tenth Circuit addressed the issue of "whether the ADA prohibits an employer from operating a long-term disability benefits plan which distinguishes between physical and mental disabilities" in *Kimber v. Thiokol Corp.*¹³⁵ The plaintiff in this case brought suit against his employer upon the discontinuance of his disability benefits after two years.¹³⁶ The employer's benefit plan capped coverage for mental conditions at twenty-four months, yet afforded coverage for physical disabilities until age sixty-five.¹³⁷ The court admittedly "adopted" the reasoning of several other circuits, finding in favor of the defendant-employer.¹³⁸ The court reasoned, in part: "While [Thiokol's disability] plan differentiated between types of disabilities, this is a far cry from a specified employee facing differential treatment due to her disability. Every [Thiokol] employee had the opportunity to join the same plan with the same schedule of coverage, meaning that every [Thiokol] employee received equal treatment."¹³⁹

The irony of this case is that the plaintiff initially took leave of absence due to complications resulting from his diabetic condition, which would have afforded him coverage until age sixty-five, assuming

¹³² *Id.* at 1116.

¹³³ *Id.*

¹³⁴ *Id.* at 1117.

¹³⁵ 196 F.3d 1092, 1102 (10th Cir. 1999).

¹³⁶ *Id.* at 1097.

¹³⁷ *Id.* at 1095.

¹³⁸ *Id.* at 1101.

¹³⁹ *Id.*

that his disability continued.¹⁴⁰ His benefits were capped, however, only at the point when his physician advised his employer that he could not return to work due to the depression, mild dementia and anxiety disorder which he was experiencing “secondary to his diabetes.”¹⁴¹ The employer, in turn, “found that Mr. Kimber was totally disabled ‘due, at least in significant part to a mental condition.’”¹⁴²

The District of Columbia Circuit addressed a related issue in *Modderno v. King*.¹⁴³ In that case, the defendant-employer’s benefit plan limited mental health care benefits to a \$75,000 lifetime maximum, with no such corresponding limitation placed on physical health care benefits.¹⁴⁴ The plaintiff-employee, who suffered from a mental illness, filed suit against her employer, alleging that the disparity in coverage between mental and physical health care violated § 504 of the Rehabilitation Act (the mother Act of the ADA).¹⁴⁵

Section 504 of the Rehabilitation Act provides: “No otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from . . . participation in, be denied the benefits of, or be subjected to discrimination under any . . . program or activity conducted by any Executive agency”¹⁴⁶ The court was charged with deciding “whether the Plan’s differential treatment of mental and physical illness excludes [the plaintiff] from participation in, denies her the benefits of, or subjects her to discrimination within the meaning of the statute.”¹⁴⁷ The court ultimately determined that “distinctions between mental and physical care are no more vulnerable under § 504 than are completely generalized limits.”¹⁴⁸

Alternatively, the plaintiff argued that the 1992 amendment to the Rehabilitation Act, which incorporated the standards of several sections of the ADA into § 504, saved her case.¹⁴⁹ The amendment reads: “The standards used to determine whether this section has been violated in a complaint alleging employment discrimination under this section shall be the standards applied under Title I of the [ADA] . . . and the provisions of sections 501 through 504, and 510, of the [ADA] . . . as such sections relate to employment.”¹⁵⁰ In response to the allegation, and as an ulti-

¹⁴⁰ See *id.* at 1096.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ 82 F.3d 1059 (D.C. Cir. 1996).

¹⁴⁴ *Id.* at 1060.

¹⁴⁵ *Id.*

¹⁴⁶ 29 U.S.C. § 794(a) (2001).

¹⁴⁷ *Modderno*, 82 F.3d at 1060.

¹⁴⁸ *Id.* at 1062.

¹⁴⁹ *Id.* at 1063.

¹⁵⁰ *Id.* (citing Rehabilitation Act Amendments of 1992, Pub. L. No. 102-569, § 506, 106 Stat. 4344 (codified at 29 U.S.C. § 794(d))).

mate rejection of the plaintiff's claim, the court referred the plaintiff to § 501(c) of the ADA, which creates a safe-harbor for insurance plans.¹⁵¹

III. MENTAL ILLNESS IN THIS COUNTRY

Some diseases are more politically 'in' than others. We all know the more political backing there is, the more attention, the more funds, and the more patient-protection legislation. My guess is that if AIDS rates a 10, then breast cancer is a 7, prostate cancer is a 6 . . . Yes, you guessed it. I am unable to assign a number to the mental health category. If I have to judge by the coverage in the popular press, this category is close to the bottom of the food-chain.¹⁵²

Mental illnesses are brain disorders disruptive of a person's thinking, feeling, moods, and ability to relate to others.¹⁵³ In much the same way as diabetes is a disorder of the pancreas, mental illnesses are disorders of the brain, often resulting in a "diminished capacity for coping with the ordinary demands of life."¹⁵⁴ Contrary to lingering public perception, mental illnesses are not indicative of personal weakness, lack of character, or poor upbringing.¹⁵⁵

As of 1994, the federal government estimated that 3.3 million American adults — approximately two percent of the population — had a serious mental illness.¹⁵⁶ Mental illness, including suicide, accounts for over fifteen percent of the burden of disease in established market economies such as the United States.¹⁵⁷ That figure constitutes more than the disease burden caused by all cancers combined.¹⁵⁸ "[M]ajor depression rank[s] second only to ischemic heart disease in magnitude of disease burden in established market economies."¹⁵⁹ In fact, mental dis-

¹⁵¹ *Id.*

¹⁵² B.G. Erengil, *Managed Care: What You Don't Know Can Hurt You!*, Wellness Web, at <http://www.wellweb.com/GRASS/bgopin.html> (last visited Nov. 10, 1999) (emphasis added).

¹⁵³ Nat'l Alliance for the Mentally Ill, *What Is Mental Illness?*, at <http://www.nami.org/disorder/whatis.html> (last visited Nov. 10, 1999).

¹⁵⁴ *Id.*

¹⁵⁵ *See id.*

¹⁵⁶ CORNELL UNIV., *supra* note 31, at 1.

¹⁵⁷ Nat'l Inst. of Mental Health, ". . .the Burden of Psychiatric Conditions Has Been Heavily Underestimated. . ." *The Impact of Mental Illness on Society — Science on Our Minds 2001*, at <http://www.nimh.nih.gov/publicat/burden.cfm> (last visited Nov. 10, 1999).

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* As of 1990 unipolar major depression accounted for 6.8% of the disease burden in established market economies, whereas ischemic heart disease accounted for 9%. Unipolar major depression ranked above cardiovascular disease, road traffic accidents and lung cancers, to name a few. However, "projections show that with the aging of the world population and the conquest of infectious diseases, psychiatric and neurological conditions could increase their share of the total global disease burden by almost half, from 10.5 percent of the total burden to almost 15 percent in 2020. *Id.*

orders account for four of the ten leading causes of disability for persons ages five and older.¹⁶⁰ Major depression is the leading cause of disability in "developed" nations, such as the United States.¹⁶¹ Also near the top of these rankings are manic-depressive illness, schizophrenia, and obsessive-compulsive disorder.¹⁶²

A. SELECT TYPES OF MENTAL ILLNESS

Depression directly and indirectly costs the United States over thirty billion dollars per year.¹⁶³ Each year, almost nineteen million American adults suffer from a depressive illness.¹⁶⁴ Nearly two of the thirty-four million Americans ages sixty-five and older suffer from depression.¹⁶⁵ The number of women suffering from major depressive disorders each year is nearly double that of men.¹⁶⁶ Besides the obvious emotional toll depression has on its sufferers and their families, depression also increases the risk of having a heart attack considerably.¹⁶⁷ More specifically, according to a recent study that covered a thirteen-year period, individuals with a history of major depression were four times as likely to suffer a heart attack compared to people without such a history.¹⁶⁸ The National Institute of Mental Health has estimated that the magnitude of disability suffered by individuals with major depression equals that associated with blindness or paraplegia.¹⁶⁹

More than 2.3 million adult Americans suffer from bi-polar disorder.¹⁷⁰ As many as twenty percent of people with manic-depressive illness commit suicide.¹⁷¹ Suicide is not only the concern of manic-depressives however, as in 1996, approximately 31,000 people died from suicide in the United States.¹⁷² Ten percent of the estimated two million adult Americans suffering from schizophrenia, for instance, eventually commit suicide.¹⁷³ More generally, nearly all suicide victims have a

¹⁶⁰ Nat'l Inst. of Mental Health, *Improving the Nation's Health*, at <http://www.nimh.nih.gov/publicat/improve.cfm> (last visited Nov. 10, 1999).

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ Nat'l Inst. of Mental Health, *The Numbers Count*, at <http://www.nimh.nih.gov/publicat/numbers.cfm> (last visited Nov. 10, 1999).

¹⁶⁴ *Id.*

¹⁶⁵ Nat'l Inst. of Mental Health, *Educating Older Americans and Health Professionals about the Risks of Depression*, at <http://www.nimh.nih.gov/events/prolderadults.cfm> (last visited Nov. 10, 1999).

¹⁶⁶ See Nat'l Inst. of Mental Health, *supra* note 163.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *Id.*

diagnosable mental disorder, most commonly depression or a substance abuse disorder.¹⁷⁴ Suicide was the third leading cause of death among 15 to 24 year olds in 1996.¹⁷⁵

Over 19 million Americans suffer from anxiety disorders, including panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, phobias and generalized anxiety disorder.¹⁷⁶ Many of them have co-occurring disorders such as depression, alcohol or drug abuse, or other mental disorders.¹⁷⁷ Collectively, anxiety disorders were estimated to have cost the nation \$46.6 billion in 1990.¹⁷⁸

B. DIAGNOSIS AND TREATMENT

The majority of people suffering from mental disorders can be accurately diagnosed and effectively treated.¹⁷⁹ In fact, treatments for mental disorders are actually "better studied and more effective than those for many other common, chronic human illnesses."¹⁸⁰ The majority of people "who have received treatment for mental illnesses show genuine improvement over time and lead stable, productive lives."¹⁸¹

Despite the availability of effective treatments, treatment services have not been liberally provided.¹⁸² Americans rely primarily on health insurance to pay their medical bills, yet many insurance plans either severely limit or entirely deny coverage for mental disorders.¹⁸³ A misconception exists "that providing parity — coverage for mental illnesses on the same level as other disorders — will 'break the bank' and leave little money to provide services to treat major medical disorders."¹⁸⁴ Notably, "[t]his myth developed during an era when most insurance companies offered 'fee-for-service' plans . . . however, there has been an explosive growth in managed care, which has had a powerful braking effect on all aspects of health care."¹⁸⁵ The National Institute of Mental Health recently examined the provision of mental health services in the context of managed care, and concluded that the combination of parity and man-

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

¹⁷⁶ Nat'l Inst. of Mental Health, *Anxiety Disorders Education Program*, at <http://www.nimh.nih.gov/anxiety> (last visited Nov. 10, 1999) [hereinafter *Anxiety Disorders*].

¹⁷⁷ *Id.*

¹⁷⁸ Nat'l Inst. of Mental Health, *Quick Facts About Anxiety Disorders*, at http://www.nimh.nih.gov/anxiety/anxiety/idx_fax.htm (last visited Oct. 10, 2001).

¹⁷⁹ See Nat'l Inst. of Mental Health, *The Equivalence of Mental Illnesses with General Illnesses*, at <http://www.nimh.nih.gov/publicat/equal.cfm> (last visited Mar. 13, 2001) [hereinafter *Equivalence of Mental Illnesses*].

¹⁸⁰ *Id.*

¹⁸¹ CORNELL UNIV., *supra* note 31, at 2.

¹⁸² See *Equivalence of Mental Illnesses*, *supra* note 179.

¹⁸³ See *id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

aged care would likely result in overall lowered mental health treatment costs and lower premiums.¹⁸⁶

Due to a widespread lack of understanding and the stigma associated with mental disorders, many people suffering from them remain undiagnosed and untreated.¹⁸⁷ In a day and age when treatments for mental disorders have proven effective,¹⁸⁸ when the body of scientific knowledge regarding mental health has grown exponentially, and when high profile individuals such as Tipper Gore have revealed their own personal struggles with mental illness, one must ask, emphatically: Why? One thing is certain. The stigma associated with mental illness has supported the disparity in health care coverage. Parity may help lessen societal fear of mental illness, thereby encouraging mentally ill individuals to seek treatment.

Some participants in the 1995 Center for Mental Health Services ADA Roundtable expressed the view that the entertainment and news media offered stigmatizing images of people with psychiatric disabilities.¹⁸⁹ Such images significantly contribute to the presence and prevalence of prejudice against the mentally ill.¹⁹⁰ Participants noted the media's tendency to highlight the mental health problems of people who commit violent acts.¹⁹¹ Indeed, a 1993 study by George Gerbner of the University of Pennsylvania concluded that the mentally ill were the most negatively portrayed of all stigmatized minority groups in prime-time television.¹⁹² In particular, mentally ill characters are more likely to portray villains than heroes, and they are often made to seem generally incompetent.¹⁹³ "Whatever the root of the prejudice, the continuous exposure to such images reinforces and promotes negative attitudes toward people with mental illness."¹⁹⁴

United States Surgeon General Dr. David Satcher recently issued a groundbreaking report on mental health — notably the first of its kind ever issued.¹⁹⁵ In it, the Surgeon General recognized the "inextricably intertwined relationship between our mental health and our physical health and well-being" and opened: "[M]ental health is often an after-

¹⁸⁶ *Id.*

¹⁸⁷ *Anxiety Disorders*, *supra* note 176.

¹⁸⁸ *Id.*

¹⁸⁹ MANCUSO, *supra* note 1, at 11.

¹⁹⁰ *Id.*

¹⁹¹ *Id.* at 11-12.

¹⁹² *Id.* at 12.

¹⁹³ *Id.*

¹⁹⁴ *Id.*

¹⁹⁵ Nelba Chavez et al., *Foreward* to OFFICE OF THE U.S. SURGEON GEN., U.S. PUB. HEALTH SERV., *MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL* (1999), available at <http://www.surgeongeneral.gov/library>.

thought and illnesses of the mind remain shrouded in fear and misunderstanding.”¹⁹⁶

He estimated that mental disorders affect nearly one in five Americans each year, “yet continue too frequently to be spoken of in whispers and shame.”¹⁹⁷ Dr. Satcher praised contemporary mental health research for the extent to which it has “mended the destructive split between ‘mental’ and ‘physical’ health,” and yet noted that “the mental health field is plagued by disparities in the availability of and access to its services.”¹⁹⁸ The Surgeon General issued the report as a call to action, in part, to address the problem of health insurance with inadequate mental health benefits.¹⁹⁹ “We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect . . . barriers. It is time to take them down.”²⁰⁰

According to the Surgeon General’s Report, about 15 percent of all adults and 21 percent of U.S. children and adolescents utilize mental health care services each year.²⁰¹ “[D]uring a one-year period, about one in five American adults — or 44 million people — have diagnosable mental disorders.”²⁰² Roughly 28 percent of the population has either a mental *or* addictive disorder,²⁰³ yet a mere eight percent of the population both has a diagnosable disorder and uses mental health services, leaving over two-thirds of adults with diagnosable mental disorders who do not receive treatment.²⁰⁴ Similarly, the majority of children with mental disorders are not receiving mental health care.²⁰⁵

C. COST OF TREATMENT

The ADA is, at its core, a civil rights law, grounded in the freedoms guaranteed in the Bill of Rights. As such, the rights and freedoms codified in the ADA should not be subject to a debate on their cost, any more than the rights of women, minorities, or religious groups.²⁰⁶

The “1998 Robert Wood Johnson national household telephone survey revealed that 11 percent of the general population considered themselves in need of mental or addictive services, while about 25 percent of these individuals reported difficulties in obtaining such treatment.”²⁰⁷

¹⁹⁶ *Id.*

¹⁹⁷ OFFICE OF THE U.S. SURGEON GEN., *supra* note 195, at Preface.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ *Id.* at 405.

²⁰² *Id.* at 408.

²⁰³ *See id.*

²⁰⁴ *Id.*

²⁰⁵ *Id.* at 409.

²⁰⁶ NAT’L COUNCIL ON DISABILITY, *supra* note 4, at 11.

²⁰⁷ OFFICE OF THE U.S. SURGEON GEN., *supra* note 195, at 409.

Concern about “costs was listed as the highest reason for not receiving care, by 83 percent of the uninsured and 55 percent of the privately insured listing this reason.”²⁰⁸

According to the Surgeon General’s Report, “[s]ixteen percent of the U.S. adult population — largely the working poor — have no health insurance at all,”²⁰⁹ and “[m]any others are inadequately insured.”²¹⁰ The report states further that “[a]lthough some state/local/and other Federal government support goes to those who are underinsured in the private and public insured groups, these funds are primarily allocated to the uninsured population.”²¹¹ Approximately “sixty-one percent of the population has employment-based private insurance.”²¹² This figure makes clear the “importan[ce] . . . [of] ensur[ing] that the private sector can meet the full treatment needs of [its] charges.”²¹³

Mental disorders are an undoubtedly emotional and financial burden on ill individuals and their families. Our Nation also bears a portion of the brunt “in reduced or lost productivity (indirect costs) and in medical resources used for care, treatment, and rehabilitation (direct costs).”²¹⁴

1. *Indirect costs of mental illness*

The Surgeon General’s Report indicates that “[i]ndirect costs of all mental illness imposed nearly a \$79 billion loss on the U.S. economy in 1990. Most of that amount (\$63 billion) reflected morbidity costs — the loss of productivity in usual activities because of illness.”²¹⁵ However, “indirect costs also include nearly \$12 billion in mortality costs,”²¹⁶ and nearly \$4 billion in other types of productivity losses.²¹⁷ These indirect cost estimates do not even begin to reflect the pain and suffering also associated with mental illness.²¹⁸

2. *Direct costs*

As for the direct costs of mental illness, mental health insurance coverage “is typically less generous than . . . [that for] general health

²⁰⁸ *Id.*

²⁰⁹ *Id.* at 407.

²¹⁰ *Id.*

²¹¹ *Id.* at 415, Table 6-3.

²¹² *Id.* at 415, Table 6-3.

²¹³ *Id.* at 408.

²¹⁴ *Id.* at 411.

²¹⁵ *Id.* Such loss includes “lost or reduced productivity at the workplace, school and home.”

²¹⁶ *Id.* Mortality costs reflect “lost productivity due to premature death.”

²¹⁷ *Id.* Productivity losses reflect (1) the loss to society of the productivity of mentally ill, incarcerated individuals and (2) the time spent by individuals providing family care for the mentally ill.

²¹⁸ *Id.*

insurance coverage.”²¹⁹ In response to this discrepancy, the “government plays a larger role in financing mental health services compared to overall health care.”²²⁰ Notably, “recent efforts to destigmatize dementias and improve care have removed some insurance coverage limitations.”²²¹ For instance, “[o]nce mostly the province of the public sector, Alzheimer’s disease now enjoys more comprehensive coverage, and care is better integrated into the private health care system. Inequities in coverage are diminishing.”²²² Alzheimer’s disease represents the success story — an illness once discarded to the “senility” or “crazy” backburner is now the subject of social understanding and compassion.

National expenditures for treatment of mental illness amounted to \$66.7 billion in 1996.²²³ That figure represents a 7.2 percent increase in the average annual expenditures for the treatment of mental health, alcohol and other drug abuse (“MHAOD”) between 1986 and 1996.²²⁴ To put that figure in proper perspective, note that there was an 8.3 percent average annual growth rate for national health care expenditures.²²⁵ Hence, the “MHAOD spending growth rate was slower than the growth rate for national health care expenditures.”²²⁶ Moreover, “[t]he private insurance share of MHAOD expenditures remained relatively constant between 1986 and 1996.”²²⁷ Further, MHAOD expenditures represented only 8.1 percent of the \$942.7 billion in national health care expenditures in 1996.²²⁸ This represents a decrease from 1986, when MHAOD treatment expenditures were nine percent of total national health expenditures.²²⁹

In 1996, approximately 53 percent (\$37 billion) of the funding for mental health treatment came from taxpayers.²³⁰ “Of the 47 percent (\$32 billion) of expenditures from private sources, more than half (\$18 billion) were from private insurance.”²³¹ Out-of-pocket payments com-

²¹⁹ *Id.* at 412.

²²⁰ *Id.* In 1996, the United States spent \$69 billion on mental health services. *Id.* at 413.

²²¹ *Id.* at 413.

²²² *Id.*

²²³ *Substance Abuse Spending Continues Downward Trend*, JOIN TOGETHER ONLINE, Sept. 30, 1998 at http://www.jointogether.org/sa/resources/funding/news/reader.html?Object_ID=255584 (last visited on Apr. 9, 2001).

²²⁴ SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., NATIONAL EXPENDITURES FOR MENTAL HEALTH, ALCOHOL AND OTHER DRUG ABUSE TREATMENT (1996), at <http://www.health.org/mhaod/spending.html>.

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.*

²²⁸ JOIN TOGETHER ONLINE, *supra* note 223.

²²⁹ *Id.*

²³⁰ OFFICE OF THE U.S. SURGEON GEN., *supra* note 195, at 413.

²³¹ *Id.*

prised most of the remainder.²³² In other words, the mentally ill themselves funded their own treatment to nearly the same extent as did their private insurers. More specifically, “for a family with mental health treatment expenses of \$35,000 a year, the average out-of-pocket burden is \$12,000; for those with \$60,000 in mental health expenses a year, the burden averages \$27,000.”²³³ In contrast, the out-of-pocket expense of a family paying for medical or surgical treatment is only \$1,500 and \$1,800, respectively.²³⁴

“[O]utpatient prescription drugs, which account for about 9 percent of total mental health direct costs, represented one of the fastest-rising expenses for mental health services.”²³⁵ “The higher than average growth rate (almost ten percent) of spending for prescription drugs reflects, in part, the increasing availability and application of medications of demonstrable efficacy in treating mental disorders.”²³⁶ Recent case law regarding the availability of corrective measures may spike this figure even more in the future, since a mentally ill individual whose ailment is treatable by means of medication is no longer considered “disabled” under the ADA.²³⁷

3. *Private health insurance*

Not surprisingly, health insurance is one of the most important factors determining whether one has both general and mental health care services.²³⁸ Eighty-four percent of Americans have some sort of insurance coverage — principally workplace-obtained private insurance.²³⁹ However, the adequacy of such insurance for mental health care varies considerably, depending on plans and sponsors.²⁴⁰ In 1996, private plans provided “more than \$32 billion . . . for mental health services . . . *almost \$12 billion [of which] came from client out-of-pocket payments*, and more than \$2 billion [of which] came from other private sources.”²⁴¹

There has been an increasing trend of insurance carriers limiting coverage for mental health care services in the private employment

²³² *Id.*

²³³ *Id.* at 427.

²³⁴ *See id.*

²³⁵ *Id.* at 416.

²³⁶ *Id.*

²³⁷ *See* Sutton v. United Air Lines, Inc., 119 S. Ct. 2139, 2146 (1999) (persons are not to be evaluated in their “hypothetical uncorrected state,” but rather are to be evaluated with reference to the corrective measures available to them); *see also* Murphy v. UPS, 119 S. Ct. 2133 (1999); Higgins v. New Balance Athletic Shoe, Inc., 194 F.3d 252 (1st Cir. 1999); Ivy v. Jones, 192 F.3d 514, 516 (5th Cir. 1999)

²³⁸ OFFICE OF THE U.S. SURGEON GEN., *supra* note 195, at 413.

²³⁹ *See id.* at 419.

²⁴⁰ *Id.*

²⁴¹ *Id.* (emphasis added)

realm.²⁴² As noted above, however, private insurance coverage for prescription drugs has expanded dramatically over the past fifteen years.²⁴³ Mental and physical health insurance coverage has actually achieved parity in the area of pharmaceuticals.²⁴⁴ Such a dramatic “shift in mental health spending in private insurance toward pharmaceutical agents,”²⁴⁵ should give anyone paying attention pause, however. Arguably, many may view pharmaceutical agents as quick fixes to the problems associated with mental health insurance coverage. The parity “achieved” with regard to pharmaceutical coverage, in light of the increasing disparity between general mental and physical health care coverage, is therefore suspicious at best.

Why is private health insurance generally more restrictive in coverage of mental illness than in coverage for somatic illness? Because it can afford to be; namely, the public sector exists as a guarantor of “catastrophic care” for the uninsured and underinsured, thereby permitting or even encouraging the private sector to “avoid financial risk and focus on acute care of less impaired individuals, most of whom [receive] health insurance benefits through their employer.”²⁴⁶

Individuals with mental illness are left paying out-of-pocket for a higher proportion of mental health services than they would for general health services, “fac[ing] catastrophic financial losses (and/or transfer to the public sector) when the costs of their care [exceed] their limits.”²⁴⁷ Ironically, the very purpose of health insurance is to help shield individuals from catastrophic financial loss.²⁴⁸ Insurance companies’ lower annual or lifetime limits on mental health care leave patients and their families exposed to profound financial risks.²⁴⁹ “The legacy of the public mental health system safety net as the provider of catastrophic coverage encouraged such practices.”²⁵⁰ Coverage limitations reduce appropriate use of mental health care services and leave individuals to bear catastrophic costs themselves.²⁵¹

Fee-for-service insurance, the predominant method of financing health care as late as 1988, has given way to various management techniques such that insurance that used “unmanaged fee-for-service” as its payment mechanism has decreased from 71 percent to 15 percent in the

²⁴² See *id.* at 417.

²⁴³ See *id.*

²⁴⁴ *Id.* at 419.

²⁴⁵ *Id.*

²⁴⁶ *Id.* at 418.

²⁴⁷ *Id.*

²⁴⁸ *Id.*

²⁴⁹ *Id.* at 420.

²⁵⁰ *Id.*

²⁵¹ *Id.*

past decade.²⁵² As per the 1999 Surgeon General's report, "[m]anaged care arrangements (HMO, PPO, or POS plans), which fundamentally alter the way in which health care resources are allocated, now cover the majority (56 percent) of Americans."²⁵³ Therefore, access to mental health services is now increasingly under the supervision of managed behavioral care companies and employers.²⁵⁴ "[M]ental health services associated with private insurance, public insurance, and public direct-service programs often have managed mental health care arrangements that are organized differently than are overall health services."²⁵⁵

If the fear of unnecessary utilization was a primary reason behind limited mental health care benefits in the past, one might expect such benefit limits to fall by the wayside in light of the increasingly managed health care system of today. The "hazard of unnecessary utilization need not be addressed through benefit design" in a managed care system.²⁵⁶ Managed care reduces cost in several ways, including by (1) "shifting treatment from inpatient to outpatient settings," (2) "negotiat[ing] discounted hospital and professional fees," and (3) "using utilization management techniques to limit unnecessary services."²⁵⁷ Hence, at least theoretically, unnecessary utilization is "eliminated at the source, on a case-by-case basis."²⁵⁸

Approximately 177 million Americans are now covered under managed behavioral health care organizations.²⁵⁹ In the event of the expansion of mental health care benefits, it would be possible for managed mental health care plans "to tighten the level of supply-side controls to maintain costs at a desired level."²⁶⁰ Managed care, then, no doubt reduces the cost of mental health services.²⁶¹ There remains the risk, however, that such a focus on cost-containment may lead to undertreatment because the supply-side controls utilized by managed care programs may be exercised too liberally.²⁶² However, despite warranted concern about managed care's relation to potential undertreatment, the actual impact of managed care's cost reductions has been understudied.²⁶³ Rather, some long-term case studies have noted that the

²⁵² *Id.* at 422.

²⁵³ *Id.* (citation omitted)

²⁵⁴ *See id.*

²⁵⁵ *Id.*

²⁵⁶ *Id.* at 423.

²⁵⁷ *Id.*

²⁵⁸ *Id.*

²⁵⁹ *See id.* (citation omitted)

²⁶⁰ *Id.*

²⁶¹ *See id.*

²⁶² *See id.*

²⁶³ *See id.* at 424.

probability of using mental health care will actually increase after managed behavioral health care is implemented in private insurance plans.²⁶⁴

IV. PROPOSAL

A. SUPREME COURT

As one option, this note considers proposing that the Supreme Court rule liberally on the matter of insurance coverage. There are two major problems with such a proposal however. First, the federal circuits that have ruled on the issue of parity with respect to mental and physical health care coverage in the private employment realm are in agreement that the ADA does not require such a notion. The Supreme Court is, therefore, unlikely to grant certiorari, given that there is apparently nothing for it to "resolve" in terms of confusion or disagreement with respect to the federal legislation.

Even if the United States Supreme Court grants certiorari, any plaintiff-favorable action on the part of the Supreme Court with respect to this issue would constitute an absolute contradiction of federal case law precedent. While such a scenario is by no means prohibited, it is unusual nonetheless. Second, a favorable Supreme Court ruling would appear to contradict other highly authoritative interpretations of the ADA, two of which the Fourth Circuit relied upon in rendering its decision.²⁶⁵

Despite these problems, the Supreme Court should revisit these issues. First, it is not beyond reason to suggest that the various circuits have relied too heavily on each other's analyses and, perhaps, not afforded the issue the proper and thorough consideration that it surely deserves. For instance, in *Kimber v. Thiokol Corp.*, the court stated: "This issue has been argued extensively in the other circuits and we see no need to address it at length here."²⁶⁶ The court went on to offer one page of reasoning to support its holding, in which it merely quoted from various other circuits' prior opinions on the issue. No doubt that this is, to an extent, common practice among courts of appeals, but both the issue at hand and the ADA itself are too cumbersome to dismiss with one page of virtual plagiarism.

A second and related reason to challenge the Supreme Court's silence even in the face of the federal courts' unanimity is the enormous effect the ADA has on the disabled. Mental illness adversely affects too great a percentage of the population not to be addressed by the highest

²⁶⁴ See *id.*

²⁶⁵ See *Rogers v. Dep't of Health & Envtl. Control*, 174 F.3d 431, 432 (4th Cir. 1999) (relying on S. Rep. 101-116, at 85 (1989); H.R. Rep. 101-485, at 137 (1990), reprinted in 1990 U.S.C.C.A.N. 267, 420; also relying on the EEOC's "interim policy guidance").

²⁶⁶ 196 F.3d 1092, 1101 (10th Cir. 1999).

court in this country. Since only 1990, eight of the twelve Circuits have directly addressed the issue. Why? Because it was brought before them by people who had been, no doubt, discriminated against based on their mental illness. The plaintiffs in the cases cited in Part III undoubtedly believed that the spirit of the ADA disallowed such blatantly unfair practices which do indeed discriminate against the millions of people directly affected by mental illness. It is simply insufficient for the federal courts to have dismissed such claims on the basis of the fact that the challenged insurance plans did not adversely affect the mentally ill's access to *physical* health care benefits.

The Supreme Court has never held that it is unlawful under the ADA or the Rehabilitation Act to give preferential treatment to one disability over another. In fact, in *Traynor v. Turnage*,²⁶⁷ the Supreme Court upheld, under section 504(a) of the Rehabilitation Act,²⁶⁸ the extension of educational benefits to one class of disabled persons and not to others. According to the Court, the preferential treatment of one disability over another was permissible under section 504(a) of the Rehabilitation Act because "there is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons."²⁶⁹ In reaching this holding, the Court emphasized that "the central purpose of § 504 . . . is to assure that handicapped individuals receive 'evenhanded treatment' in relation to nonhandicapped individuals."²⁷⁰

Along the same lines, but perhaps even more indicative of the Supreme Court's opinion on the matter currently at issue, is a 1985 case that decided that the effect upon the handicapped of a state's reduction in annual inpatient coverage was not cognizable under section 504 of the Rehabilitation Act.²⁷¹ In that case, the Court stated that an employer need only provide an employee "meaningful access" to his or her employer's benefit.²⁷² While the Court conceded that "to assure meaningful access, reasonable accommodations in the grantee's program or benefit may have to be made,"²⁷³ it ultimately found that the facially neutral reduction in inpatient coverage was not discriminatory in that the reduction "will leave both handicapped and nonhandicapped Medicaid users with identical . . . hospital services . . ."²⁷⁴ This reasoning, which mistakenly pits the disabled against the nondisabled, is mirrored in the recent

²⁶⁷ 485 U.S. 535 (1988).

²⁶⁸ 29 U.S.C. § 794(a) (2001).

²⁶⁹ *Traynor*, 485 U.S. at 549.

²⁷⁰ *Id.* at 548.

²⁷¹ *Alexander v. Choate*, 469 U.S. 287, 289 (1985).

²⁷² *Id.* at 301.

²⁷³ *Id.*

²⁷⁴ *Id.* at 302.

opinions of the courts of appeals cited above in Part III. The Supreme Court went on to state that, while the Rehabilitation Act "seeks to assure evenhanded treatment . . . [it] does not . . . guarantee . . . equal results."²⁷⁵ In a disappointing display of statutory interpretation, the Court stated that "[s]ection 504 does not require the State to alter [its] definition of the benefit being offered simply to meet the reality that the handicapped have greater medical needs."²⁷⁶

Further indication that new legislation, as opposed to another judicial opinion, is necessary is the Seventh Circuit's ruling in *EEOC v. CNA Ins. Cos.*²⁷⁷ In *EEOC*, the Seventh Circuit stated that it would not sustain a claim for parity "[w]ithout far stronger language in the ADA supporting" such.²⁷⁸ The court noted:

Few, if any, mental health advocates have thought that the result they would like to see has been there all along in the ADA. This is well-illustrated by the debate over a proposed amendment to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat.1936 (1996). The amendment, which was defeated before final passage of the bill, would have required parity of coverage for mental and physical conditions . . . This debate reinforces our conclusion based on the language of the ADA that the issue of parity among physical and mental health benefits is one that is still in the legislative arena.²⁷⁹

Ultimately, the court held that CNA's long-term disability plan's distinction between mental health benefits and other benefits did not violate Title I of the ADA.²⁸⁰

B. NEW LEGISLATION

While the ADA Manual claims that an employer may not "limit, segregate, or classify" an employee such that the employee's employment opportunities are restricted,²⁸¹ that is exactly the state of affairs with respect to mental health insurance in this country. Although the ADA has been read to mandate that employers have a duty to accommodate their employees' disabilities "in order to remove barriers that could impede the ability of qualified individuals with disabilities to perform

²⁷⁵ *Id.* at 304.

²⁷⁶ *Id.* at 303.

²⁷⁷ 96 F.3d 1039 (7th Cir. 1996).

²⁷⁸ *Id.* at 1044.

²⁷⁹ *Id.*

²⁸⁰ *Id.* at 1045.

²⁸¹ See Zuckerman & Parry, *supra* note 27, at 29.

their jobs,”²⁸² legislative commentary and federal courts’ decisions following the enactment of the ADA have done little to remove such barriers for the mentally ill. Statistics on the mental illness crisis in this country make clear that inequitable health insurance barriers in the private employment realm have, in fact, impeded the ability of qualified mentally ill individuals from performing their jobs. While the ADA-mandated removal of architectural and transportation barriers was a step in the right direction, these types of barriers are not the only ones faced by the disabled.²⁸³ Legislation which duly recognizes the *full* plight of the disabled — including that of the overwhelming number of mentally ill Americans — is in order.

In *Modderno*,²⁸⁴ the D.C. Circuit determined that section 504 of the Rehabilitation Act does not mandate parity in health care coverage of mental and physical disabilities. In doing so, however, the court also conceded: “Perhaps mentally disabled individuals are more vulnerable to discrimination than the physically disabled. If so, then Congress might wish to enact a statute affording the mentally disabled special protection. But the Rehabilitation Act is simply not such a statute.”²⁸⁵

This call for parity legislation is primarily motivated by the desire to cover mental illness *fairly* with respect to somatic illness. Effective parity legislation would require all insurers to offer mental health coverage equivalent to the coverage offered for all other disorders. Managed care’s probable ability to control costs, as explained in Part IV, without limiting benefits makes a parity mandate a more reasonably achievable possibility than it might have been under a fee-for-service system.²⁸⁶

1. *Previous efforts at parity legislation*

Prior federal legislative efforts to achieve mental health insurance parity date back to the 1970s.²⁸⁷ Passed in 1996 and implemented in 1998, the Mental Health Parity Act (“MHPA”)²⁸⁸ focused on the inequities in mental health insurance coverage only as they exist with respect to “catastrophic” benefits.²⁸⁹ The MHPA “prohibited the use of lifetime and annual limits on coverage that were different for mental and somatic illnesses.”²⁹⁰

²⁸² *McAlindin*, 192 F.3d at 1237.

²⁸³ EQUAL EMPLOYMENT OPPORTUNITY COMM’N & U.S. DEP’T OF JUSTICE CIVIL RIGHTS Div., *supra* note 5, at 29.

²⁸⁴ 82 F.3d 1059.

²⁸⁵ *Id.* at 1062.

²⁸⁶ See OFFICE OF THE U.S. SURGEON GEN., *supra* note 195, at 426.

²⁸⁷ *Id.* at 427.

²⁸⁸ Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, § 701 (codified as amended at 42 U.S.C. § 201 (1998)).

²⁸⁹ OFFICE OF THE U.S. SURGEON GEN., *supra* note 195, at 427.

²⁹⁰ *Id.*

But the MHPA was limited in a number of important ways. It was inapplicable to "[c]ompanies with fewer than 50 employees" or companies that do not offer mental health benefits.²⁹¹ "The parity provisions did not apply to other forms of benefit limits, such as per episode limits on length of stay or visit limits, or copayments or deductibles, and they did not include substance abuse treatment."²⁹² Further, the MHPA offered an exemption to those insurers whose parity implementation efforts resulted in more than a one percent rise in premium.²⁹³

Most state efforts at implementing parity legislation have closely resembled those at the federal level. Texas' legislation, for instance, is narrow in scope, including only people with *severe* mental disorders and focusing only on state employees.²⁹⁴ Maryland's scope is slightly broader, focusing on a wider range of insured populations and including, in some cases, substance abuse.²⁹⁵ The overwhelming scope and serious implications of the issue at hand, coupled with various states' failures to achieve the extent of parity required, makes clear the fact that federal legislation is necessary. This note proposes federal legislation substantially similar to the ADA, with several major exceptions.

2. *Proposed new legislation*

First, while the proposed legislation would have a safe-harbor provision for insurance companies, such provision would not be subject to liberal construction, as it has been under the ADA.²⁹⁶ Therefore, the legislation should state that all decisions regarding scope of coverage would have to be based on sound actuarial data. Otherwise, the insurance companies would be invited, as they have previously been, to make their decisions according to the societal stigma associated with mental illness. Hard-nosed oversight of the insurance industry will necessarily see private employers' compliance.

Second, the proposed legislation must mandate parity across-the-board. The burden of proof will rest solely on the insurer that any disparate treatment of disabilities is based on truly sound actuarial data.

²⁹¹ *Id.*

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ *See id.* at 428.

²⁹⁵ *See id.*

²⁹⁶ *See Leonard F.*, 199 F.3d at 18; *see also Doe*, 179 F.3d at 564 ("It is one thing to say that an insurance company may not refuse to deal with disabled persons; the prohibition of such refusals can probably be administered with relatively little interference with state insurance regulation It is another thing to require federal courts to determine whether limitations on coverage are actuarially sound"); *Ford*, 145 F.3d at 612 (construing § 501(c) to mandate underwriting based on sound actuarial principles would "require insurers to justify their coverage plans in [federal] court after a mere allegation by a plaintiff," thereby effecting a "seismic shift in the insurance business").

While a case-by-case evaluation of the soundness of actuarial data must focus on cost to *some* extent, cost alone cannot be determinative unless the estimated cost of parity will likely ruin the insurance industry.

Third, the proposed regulation must reserve a separate clause dedicated to the issue of mental health care coverage, so that there is no room for questioning congressional intent to actually, as opposed to purportedly, even the disability playing field. It is not enough that the mentally ill have health care coverage identical to their non-mentally ill "peers." They must have access to mental health care that *equals* their and others' access to physical health care.

Finally, unlike the MHPA, the proposed legislation will not exempt companies according to their number of employees. Similarly, the new legislation, instead of exempting companies that offer no mental health benefits at all, will mandate that all employers offering any kind of health care coverage whatsoever provide mental health care coverage as well, including coverage for substance abuse. The parity provisions will apply to all forms of benefit limits, such as per episode limits, limits on length of stay, visit limits, co-payments and deductibles. Lastly, no rise in premium felt by insurers, as a result of implementing parity, will constitute a permissible basis on which to exercise an exemption.

If the above proposal sounds extreme, it is only because our society has come to accept the notion that certain disabling illnesses are more legitimate, and therefore more deserving of treatment, than others. In actuality, there is nothing extreme about requiring the insurance industry and employers to base their life-altering decisions regarding health care benefits on fact rather than fiction. When sixty-one percent of Americans receive the majority of their health care coverage from private employer-provided insurance plans,²⁹⁷ it is imperative that such plans reflect reality. Mental illness is reality.

CONCLUSION

Does a disparity in health care insurance between mental and physical disabilities "adversely [affect an employee's] employment opportunities?"²⁹⁸ Most definitely, yes. And yet such a disparity has not only *not* been prohibited under the ADA, it has actually been encouraged by legislative and judicial interpretations of the ADA. A House Report released in 1990 stated that the purpose of the ADA was, in part, "to bring individuals with disabilities into the economic and social mainstream of American life."²⁹⁹ One look at the startling figures regarding economic

²⁹⁷ OFFICE OF THE SURGEON GEN., *supra* note 195, at 415, Table 6-3.

²⁹⁸ 29 C.F.R. § 1630.5.

²⁹⁹ H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2, at 99 (1990).

expenditures on mental health care in Part IV, specifically those regarding patient out-of-pocket expenditures, severely challenges the validity of that statement. Particularly in a time when appropriate treatment can alleviate, if not cure, mental illness symptoms and disability, there is no reasonable excuse for such disparity.

Presently, the large *majority* of those in need of mental health treatment do not seek it.³⁰⁰ The stigma surrounding mental illness is alive and well and serves to deter people from seeking effective treatment. "It gives insurers — in the public sector as well as the private — tacit permission to restrict coverage for mental health services in ways that would not be tolerated for other illnesses."³⁰¹ Scientific research into the sources of mental disabilities has attempted, with limited success, to discard societal misconceptions and stereotypes associated with mental illness. However, that mental illness remains, in large part, shrouded in fear and misunderstanding, is evidenced by the ADA's arguably narrow scope, the federal courts' restrictive interpretations of federal legislation, and various states' half-hearted attempts at creating "parity" legislation of their own.

As the Surgeon General recently declared, the federal government must, once and for all, "place mental illness treatment in the mainstream of health care services."³⁰² The ADA did not achieve that purpose. "The goals of the ADA — for equality of opportunity, full participation, independent living, and economic self-sufficiency — are beginning to shape our national culture."³⁰³ But we have a long way to go before they are truly realized, particularly with respect to mental health care coverage in the private employment realm. Implementation of federal legislation that does justice to the mental health care crisis described above is essential.

³⁰⁰ OFFICE OF THE SUGION GEN., *supra* note 199, at 415.

³⁰¹ *Id.* at 454.

³⁰² *Id.* at 458.

³⁰³ NAT'L COUNCIL ON DISABILITY, *supra* note 4, at 29.