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In Benjamin D. Heller's *Revolutionizing the Mental Health Parity and Addiction Equity Act of 2008*[1], he urgently calls for bold reforms to the current delivery system of mental health care coverage to minimize discriminatory practices conducted by health insurance providers. Mental health parity explains the equal treatment and coverage of mental health conditions and substance use disorders by insurance providers. Historically, mental health parity has been excessively restrictive in nature leading to discrimination against those with mental health conditions. Heller's foremost goal is to provide an adequate understanding of the relevant legal and social developments that have contributed to the continual discrimination in health insurance coverage that plague millions of Americans. In respect to Heller's legal commentary, this paper promotes an improved approach to mental health parity that functions to safeguard individuals with mental health conditions and substance use disorders in receiving adequate care and treatment in the same fashion as individuals without these conditions.

Heller develops a deliberate timeline that highlights the critical developments contributing to the current challenges in establishing mental health parity. He begins his call for a revolution to mental health parity with the gripping story of Timothy O'Clair, a notable victim of the shortcomings of mental healthcare coverage. His story in conjunction with the valiant lobbying efforts by his parents lead to the passing of Timothy's Law in New York in 2006.

[1] Heller B. D. (2017). Revolutionizing the Mental Health Parity and Addiction Equity Act of 2008. *Seton Hall law review*, *47*(2), 569–602.

Before the law was enacted, typical mental health treatment coverage was limited to 20 days of outpatient care and 30 days of inpatient care per year. This restrictive coverage led to ineffective treatment that likely contributed to his later demise and adversely impacted millions of Americans. His parents advocated for legislation that required insurance providers to offer equal coverage for physical and mental health conditions. Heller's choice to begin with his story was an effective strategy to establish pathos and demonstrate the urgent need for a revised approach to prevent any further tragedies.

Heller presents two key cases that further demonstrate the inadequacies of mental health care coverage and functioned to promulgate growing backlash throughout the country: *Edgar v MVP Health Plan* and *Hirsh v. Boeing Health and Welfare Benefits Plan*. In the Edgar's case, the plaintiff attended an out-of-network treatment provider for his mental health conditions because the plan failed to provide him with any inpatient care facilities. However, the health plan refused to reimburse him on the basis that he did not attend an in-network provider and maintained that it would only cover his treatments if they were "medically necessary" and "rendered in the most efficient and economical way." In the Hirsh case, the plaintiff's son received treatment at two in-patient facilities for his substance use disorders, yet the health plan refused to fully reimburse both institutions by claiming that the treatment needed to be a "medical necessity." Heller effectively criticizes how insurance plans fail to provide essential treatment through the exaggerated the use of "medical necessity" claims. The inclusion of these two cases competently displays the overwhelming power insurance companies have in determining whether individuals can receive treatment for their disorders, which adversely affects the daily lives of these individuals and their families. In response to the mounting resistance surrounding the discrepancies in mental health parity, the federal government passed

the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 and mandated that all "qualified health plans" include an "essential health benefits package" that provides coverage for mental health, substance use, and behavioral health treatments under the Affordable Care Act (ACA) in 2010. However, Heller highlights the inherent flaws that diminish the overall intentions of both acts which fuels his demand for augmented procedures.

The MHPAEA of 2008 includes four key provisions that intended to increase access to mental health and substance use treatment. First, it outlined that insurance providers attain the power to delineate "mental illness" on their own terms if it meets relevant state and federal laws. This enables health insurance companies to gain excessive control in determining whether treatment for individuals experiencing mental health and substance use disorders is covered. This is inherently ineffective because many insurance employees lack the medical expertise to decide what treatments are necessary for specific conditions. The next provision mandates that financial requirements for mental health and substance use treatment cannot be more restrictive than for medical and surgical care. Third, if a health insurance plan enables enrollees to seek out-of-network providers for medical and surgical care, the entity must also specify out-of-network coverage for mental health and substance use treatment as well. The final provision stipulates that treatment limitations (which includes the number of visits allowed and the caps on the number of treatments) for mental health benefits cannot be more restrictive than for medical and surgical benefits. While these provisions may seem robust on achieving mental health parity on paper, there are two exceptions in place that minimize the implementation of the act. The act allows for a "Small Employer Exemption" which enables businesses with less than 50 employees to not adhere to the provisions of the act. There is also a "Cost Exemption" rule that imposes if the total cost of group health plan increases by 2% in the first year or 1% in subsequent years,

then the group health plan also is not required to adhere to the act. The utilization of the word "or" explicitly gives insurance companies greater dominance in limiting coverage.

These two exemptions, along with various flaws, contribute to diminished adherence of the act and is applicable only under specific circumstances. The MHPAEA fails to equip insurance companies with relevant standards that make it challenging for health plans to engage in what Heller deems as an "apples to apples" comparison of mental and physical conditions. Overall, it is much easier to detect a physical condition with an x-ray, MRI, or CT scan than it is to appropriately identify a mental health condition. With this notion in mind, Heller proposes an amendment to the MHPAEA that would include improved standards or guidelines that would enable a more equal comparison of mental and physical conditions from a health insurance coverage perspective. He also champions for a standardized approach in defining "mental illness" by emphasizing the statutory language that should considered while developing the definition. For example, he evaluates the Georgia and Connecticut state enacted parity laws that both use the Diagnostic and Statistical Manual of Mental Disorders to define "mental illness" and promotes a similar standardized federal approach. In doing so, the discrepancies among insurance plans and among states would be mitigated and less inherently discriminatory.

While Heller exhibits a hefty analysis of the historical context that led to the enactment of the MHPAEA as well as the act's intrinsic weaknesses, he includes numerous strategies that make his overall argument more compelling. Foremost, he includes several statistics that display the indispensable prevalence of mental health conditions within American society. By including that one in four Americans have a diagnosable mental health condition in any given year and that two-thirds of these individuals fail to receive necessary treatment, he demonstrates the reality of the magnitude of ineffective mental health insurance coverage. He explains that 90% of

individuals that commit suicide have a diagnosable mental health condition and with suicide being the third leading cause of death for 10–24-year old's, a rational mind would assume that there would be greater treatment and protections in place to avoid the emotional and economical ramification of suicide on society. In 2003, George W. Bush commissioned a task force to analyze the current health insurance system in providing mental health coverage versus medical and surgical coverage and found that $12 billion were lost due to mortality costs from premature deaths that year. The report also found that $63 billion were lost due to loss of labor productivity and $4 billion were lost due to productivity losses for individuals incarcerated. Heller's incorporation of these staggering numbers displays that inadequate mental health treatment not only unfavorably affects the individuals experiencing the conditions but also the United States economy and penal systems. These methods further the argument of an urgent "revolution" to mental health parity legislation.

Heller declares that amendments to the MHPAEA are "incontestable" and that "indisputable bold reforms are required" to which this paper profoundly agrees. Another clever technique utilized by Heller is the admittance of a 2015 letter written by more than a dozen senators insisting there be "increased consumer protections" for individuals attempting access to vital mental health and substance use care. They did so because insurance companies were not providing many of their constituents with adequate in-network mental health and substance use treatment options. The inclusion of this letter continues to demonstrate that while the MHPAEA of 2008 and ACA of 2010 were intended to curb the inconsistencies between mental health and substance use treatment compared to medical and surgical coverage, the current legislation is quite antiquated and thus desperately requires immediate remediation.