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## Articles

Your Claim Has Been Denied: Mental Health and Medical Necessity  
Neiloy Sircar, J.D. .... 1



AMERICAN UNIVERSITY  
HEALTH LAW & POLICY BRIEF  
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Your Claim Has Been Denied: Mental Health and Medical Necessity

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# HEALTH LAW & POLICY BRIEF 2016-2017

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# LETTER FROM THE EDITORS

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Dear Reader:

On behalf of the Editorial Board and staff, we proudly present Volume 11, Issue 2 of the *Health Law & Policy Brief* (HLPB). HLPB is an online publication run by law students at American University Washington College of Law (WCL). Since its formation in 2007, HLPB has published articles on a wide array of cutting-edge topics in the areas of health law, disability law, and food and drug law. Such topics include international and domestic issues of health care compliance, fraud and abuse enforcement, health insurance payment and reimbursement issues, intellectual property issues, international human rights issues, FDA initiatives and policies, and a host of other matters. HLPB also maintains a blog on current health law issues which can be found on our website at [www.healthlawpolicy.org](http://www.healthlawpolicy.org). Furthermore, each year, HLPB organizes an original symposium on an emerging health law topic. At this year's symposium in November 2016, distinguished speakers and moderators discussed the ethical concerns of defendants with mental disabilities receiving the death penalty.

This issue features a thought-provoking article by Neiloy Sircar. Sircar argues that mental health sufferers are discriminated against as a result of structural impediments to accessing care. Sircar analyzes the requirement that mental health services be "medically necessary" and the labyrinthine frameworks for determining medical necessity. Finally, Sircar urges state and federal agencies to take action and protect mental health sufferers.

We would like to thank HLPB's articles editors and staff members who worked diligently on this issue, the blog, and our programming throughout the year. They are greatly appreciated and should be proud of their work.

For questions or information about the *Health Law & Policy Brief*, or for questions on how to subscribe to our electronic publication, please visit our website at [www.healthlawpolicy.org](http://www.healthlawpolicy.org).

Sincerely,  
Payal and Mamie

Payal Mehta            Mamie Aoughsten  
*Editor-in-Chief*      *Executive Editor*



# YOUR CLAIM HAS BEEN DENIED: MENTAL HEALTH AND MEDICAL NECESSITY

*Neiloy Sircar, J.D.\**

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## INTRODUCTION

Mental health is a vital and underserved component to overall health.<sup>1</sup> While society is familiar with cancer, a physical ailment that eats away at one's body, it is relatively unfamiliar with depression, which, if left untreated, eats away at a healthy mind and inevitably proves equally fatal.<sup>2</sup> A 2009 CDC survey showed that 11 million Americans suffered from a "serious mental illness."<sup>3</sup> Moreover, in 2011, the Centers for Disease Control and Prevention (CDC) estimated that half of Americans would suffer from mental illness in their lifetime.<sup>4</sup> Therefore, health systems need to ensure adequate care by facilitating access to mental health care without unnecessary or harmful costs on sufferers.<sup>5</sup>

Mental health sufferers come from all population groups; however, the danger of denied access to care affects vulnerable communities the most, specifically transgender individuals.<sup>6</sup> Because these populations are already marginalized, further limiting their access to essential health services compounds their tribulation.<sup>7</sup> For instance, the Substance Abuse and Mental Health Service Administration finds suicidal ideation among transgender persons to range between 38% and 65%, with suicide attempts occurring in 16% to 32% of the transgender population.<sup>8</sup> By comparison, only 3.9% of American adults overall have suicidal thoughts and 0.6% have attempted suicide.<sup>9</sup> Suicide is the tragic conclusion to depression and other mental illnesses the likes of which transgender persons are prone to suffer.<sup>10</sup> Despite both documented and intuitive

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<sup>1</sup> Kavitha Kolappa et al., *No Physical Health Without Mental Health: Lessons Unlearned?*, 91 WHO BULL. 3-3A (2013), <http://www.who.int/bulletin/volumes/91/1/12-115063.pdf> [hereinafter Kolappa]

("[M]ental illnesses are themselves risk factors that affect the incidence and prognosis of diseases traditionally classified as 'noncommunicable'...."). See also *infra* note 3.

<sup>2</sup> See Kolappa, *supra* note 1.

<sup>3</sup> Press Release, Ctrs. for Disease Control and Prevention, CDC Report Identifies Need For Increase Monitoring of Adult Mental Illness (Sept. 1, 2011), [http://www.cdc.gov/media/releases/2011/a0901\\_adult\\_mental\\_illness.html](http://www.cdc.gov/media/releases/2011/a0901_adult_mental_illness.html).

<sup>4</sup> *Id.*

<sup>5</sup> See Kolappa, *supra* note 1.

<sup>6</sup> See *infra* notes 8, 10. "Transgender" is used here as an umbrella term for the many ways in which individuals may identify themselves in accordance to their sexual and gender identities. GLAAD, <http://www.glaad.org/reference/transgender> (last visited Mar. 19, 2017).

<sup>7</sup> *Id.* As discussed elsewhere in this article, transpersons and other vulnerable communities often struggle to receive equitable treatment or consideration.

<sup>8</sup> Substance Abuse and Mental Health Serv. Admin., Dep't Health Hum. Serv., *Top Health Issues for LGBT Populations Information & Resource Kit*, HHS PUBL'N NO. (SMA) 12-4684 F-1 (2012), <https://store.samhsa.gov/shin/content/SMA12-4684/SMA12-4684.pdf> [hereinafter SAMHSA, *Top Health Issues*].

<sup>9</sup> CTRS. FOR DISEASE CONTROL & PREVENTION, SUICIDE FACTS AT A GLANCE, 1 (2015), <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf>.

<sup>10</sup> For instance, a recent study on youth found that this group had a much higher probability of experiencing depression, suffering from anxiety, attempting suicide, and engaging in self-harming activities. See Sari Reisner et al., *Mental Health of Transgender Youth in Care at an Adolescent Community Health Center: A Matched Retrospective Cohort Study*, 56 J. ADOLESCENT HEALTH 274 (2015).

mental health needs, transgender persons can face discrimination within the health care system and denial of access to mental health care.<sup>11</sup> With such hardship in accessing vital health services, it is a small wonder that many transgender persons suffer from untreated or poorly addressed mental health illnesses and condition.<sup>12</sup> A marginalized population that has poor access to mental health services is made more vulnerable when, where there is access, those services are actively denied.<sup>13</sup>

Discrimination towards mental health sufferers is most injurious when these individuals confront the need to justify their case as medically necessary.<sup>14</sup> Transgender persons commonly report experiencing insensitivity, discrimination, or harassment by their primary care providers and subsequent refusal to even go forward with a benefits claim.<sup>15</sup> Accessing mental health care can be less challenging when comorbidity between physical illness or injury and mental illness exacerbates a disease.<sup>16</sup> However, when a mental health illness is independent of a physical illness or injury, accessing mental health care can be challenging as it may not be deemed medically necessary by the insurance provider.<sup>17</sup> Transgender persons are not alone in this discrimination as their struggle to define mental health illnesses as medically necessary represents the dilemma faced by all persons with mental health illnesses.<sup>18</sup>

Consumers need a clear definition of medical necessity, and need to know what criteria are assessed when determining medical need in order to press a valid claim; however, these criteria are as difficult to obtain as clearance for mental health treatment.<sup>19</sup> There is insufficient oversight or guidance by federal or state governments even where the law gives authority to the government to clearly define medical necessity and ensure

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<sup>11</sup> See JAIME GRANT ET AL., *INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY* 6, 72 (2011), [http://www.thetaskforce.org/static\\_html/downloads/reports/reports/ntds\\_full.pdf](http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf) [hereinafter GRANT] (noting that discrimination in health care and health outcomes manifests in refusals of care, higher HIV rates than the national average, and postponed care). See also Emilia Lombardi, *Enhancing Transgender Health Care*, 91 AM. J. PUB. HEALTH 869, 869-72 (2001) (finding that health care providers have difficulty providing the care sought and needed by transgender persons, and particularly a “lack of sensitivity on the part of the health care providers” can inhibit seeking and accessing appropriate health care).

<sup>12</sup> SAMHSA, *Top Health Issues*, *supra* note 8.

<sup>13</sup> *Id.*

<sup>14</sup> *60 Minutes: Denied*, (CBS television broadcast Dec. 14, 2014), <http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes/>.

<sup>15</sup> GRANT, *supra* note 11, at 73-76, 84. One respondent is quoted for his story of a physician telling him “You want to be a boy and that’s never [going to] happen so just do yourself a favor and get over it.” *Id.* Medical necessity determinations made at the discretion of doctors harboring such attitudes, or defined by insurers unwilling to provide for more flexible determinants of mental health needs, are unlikely to favor treatment for the sufferer.

<sup>16</sup> LAWRENCE GOSTIN, *GLOBAL HEALTH LAW* 391 (2014) [hereinafter GOSTIN, *GLOBAL HEALTH LAW*].

<sup>17</sup> Daniel Skinner, *Defining Medical Necessity under the Patient and Affordable Care Act*, 73 PUB. ADMIN. REVIEW S49 (2013) [hereinafter Skinner].

<sup>18</sup> *Id.* at s52-5.

<sup>19</sup> Michael Ollove, *Despite Laws, Mental Health Still Getting Short Shrift*, PEW TRUSTS BLOG (May 7, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/07/despite-laws-mental-health-still-getting-short-shrift> [hereinafter Ollove].

compliance.<sup>20</sup> Consequently, health insurance providers have the authority to create their own definitions and criteria for medical necessity.<sup>21</sup> In doing so, health insurance providers exclude needed coverage or deny access to coverage for mental health care.<sup>22</sup> The inequity in access to mental health care, including little to no access to the criteria by which medical necessity is determined, is discriminatory against individuals who have mental health conditions.<sup>23</sup>

The purpose of this article is to show how the current medical necessity applications are denying access to mental health treatment for sufferers and consumers of private health insurance. Section I reviews contemporary background for medical necessity, particularly the health parity laws that inform the current detrimental norm for insurers defining medical necessity. Section II analyzes the multi-dimensions of medical necessity determinations to show the ambiguity and vagueness of what constitutes medical necessity. Section III asserts that private enforcement of mental health rights is woefully ineffectual and, consequently, is an inadequate safeguard for those rights. Section IV evaluates policy recommendations from scholars and experts in light of addressing mental health care access. In conclusion, the article offers proposals on how to end the discriminatory practices making medical necessity the arbiter of mental health treatment.

## I. BACKGROUND

One of the primary objectives of public health is to create the conditions for individuals and populations to enjoy the highest attainable level of physical and mental health.<sup>24</sup> There are three inseparable components to public health law: (1) a focus on population health, (2) support for communities, and (3) the provision of social justice in “fair and equitable treatment” with “particular attention” to those most marginalized or disadvantaged.<sup>25</sup> Persons who are vulnerable to harm encounter increased risk of mental health issues underscoring the reliance many populations have on the just enforcement of public health laws that provide protection from discrimination.<sup>26</sup> An effective health system must both identify and ameliorate “patterns of systemic disadvantage that...

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<sup>20</sup> *Id.*

<sup>21</sup> See Skinner, *supra* note 17, at s51 (“The devolution of the question of medical necessity to state officials and insurance providers...raises concerns about cost-cutting strategies on the part of private providers and discriminatory practices that could work their way into medical necessity determinations, which would effectively undermine covered benefits by refusing patients access to them by declaring them medical unnecessary in particular contexts.”).

<sup>22</sup> *Id.* at s50 (“[T]here remains a great deal of uncertainty as to what regulatory role, if any, the HHS will play in ensuring medical necessity determinations are evaluated based on medical rather than *political or economic calculations.*”) (*emphasis added*).

<sup>23</sup> Sara Rosenbaum, *Medical Necessity Definition Threatens Coverage for People With Disabilities*, HEALTH AFF. BLOG (Sept. 16, 2011), <http://healthaffairs.org/blog/2011/09/16/medical-necessity-definition-threatens-coverage-for-people-with-disabilities> [hereinafter Rosenbaum, *Medical Necessity*].

<sup>24</sup> LAWRENCE GOSTIN, PUBLIC HEALTH LAW 4 (2d. ed. 2008).

<sup>25</sup> *Id.* at 5.

<sup>26</sup> *Id.* at 10, 21.

undermine the prospects for well-being...”<sup>27</sup> Recently, the U.S. passed and amended health laws to address systemic discrimination against mental health sufferers (in particular by requiring parity in treatment or access to care), which is all the more pertinent when considering the mental health needs of marginalized communities.<sup>28</sup>

Mental health care is a necessary component of an effective health care and personal wellbeing, but this has not been reflected in practice or in most laws.<sup>29</sup> Mental health insurance coverage is neither uniform nor universal, even where modernity and decency have compelled legislation to require it.<sup>30</sup> If mental health coverage is offered by insurance, the standard the coverage must meet is parity with physical health coverage.<sup>31</sup> State health parity legislation may be more comprehensive than the federal parity act, and state laws may require more coverage or define terms more precisely, but not every state has taken up such legislation.<sup>32</sup>

Parity laws are not yet a panacea for the discriminatory ills plaguing mental health access. Federal and state laws, and the rules issued under their authority, do not precisely define parity; instead, insurance providers are free to make their own determinations.<sup>33</sup> Shortcomings and failures in diligent monitoring result in noncompliance by insurers and disparity in access to mental health care.<sup>34</sup> Medical necessity is a barrier to this access and to parity by permitting insurers to deny coverage without preauthorization (ostensibly, to affirm there is a medical need to the insurance provider) or by evaluation against criteria or factors unbeknownst to the policyholder.<sup>35</sup> Patients do not know what their insurer considers medically necessary, how that definition came into being, how medical necessity is defined, or how their claim is assessed.<sup>36</sup>

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<sup>27</sup> *Id.*

<sup>28</sup> GRANT, *supra* note 11, at 77-9, 82, 84.

<sup>29</sup> See GOSTIN, GLOBAL HEALTH LAW, *supra* note 16, at 390-1 (stating historically mental health has not been included in an individual’s health).

<sup>30</sup> See NAT’L CONFERENCE OF STATE LEGISLATURES, MENTAL HEALTH BENEFITS: STATE LAWS MANDATING OR REGULATING MENTAL HEALTH BENEFITS (2015), <http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx> (last visited July 5, 2017) (stating state governments vary when it comes to determining what mental health coverage entails).

<sup>31</sup> 42 U.S.C. § 300gg-26(a)(3) (2010). See also Disability Rights California, *Mental Health Parity Under California and Federal Law* (2014), <http://www.disabilityrightscalifornia.org/pubs/CM2401.pdf> (comparing California’s and federal parity laws).

<sup>32</sup> See NCSL, *supra* note 30.

<sup>33</sup> Kimberly Leonard, *Patients With Mental Illness No Better Off Under Obamacare*, U.S. NEWS & WORLD REPORT (Apr. 1, 2015), <http://www.usnews.com/news/articles/2015/04/01/health-insurance-coverage-discrimination-mental-illness> (“The definition for ‘parity’ is murky at best...[current mental health parity regulations] are not sufficiently specific to be able to make a really clear judgment.”).

<sup>34</sup> See *infra* notes 63-69 and accompanying text.

<sup>35</sup> Laura Ungar & Jayne O’Donnell, *Mental Health Coverage Unequal In Many Obamacare Plans*, USA TODAY (Mar. 9, 2015), <http://www.usatoday.com/story/news/nation/2015/03/09/johns-hopkins-study-shows-obamacare-plans-lack-mental-health-parity/24439947>.

<sup>36</sup> See Ollove, *supra* note 19.

### A. Medical Necessity, Ill Defined<sup>37</sup>

What constitutes medical necessity for a mental health need is neither uniformly defined nor consistently applied.<sup>38</sup> The Patient Protection and Affordable Care Act (ACA) does not provide overarching criteria or clear definitions of these terms.<sup>39</sup> While the ACA may help “promote predictability in health care delivery” it only partially does so because it incorporates maintaining some pre-ACA practices.<sup>40</sup> Before the ACA was enacted, the delivery of benefits was tied to whether those benefits fit a menu of covered treatments and options.<sup>41</sup> The ACA does not address medical necessity sufficiently and instead perpetuates uncertainty around accessing benefits.<sup>42</sup> Patients are left with functionally the same situation they faced before the ACA: limited, if any, access to mental health services and a discriminatory bar to hurdle to receive what their plans purport to cover.<sup>43</sup> Individuals suffering from mental illness may find the door to proper treatment closed to them.<sup>44</sup>

The Federal government sought to remedy inequitable access to mental health services through the broader expansion of coverage under the ACA and the Mental Health Parity

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<sup>37</sup> See generally Morris Landau, *The Difficulties in Defining Medical Necessity*, UNIV. HOUS. L. BLOG (2000), <https://www.law.uh.edu/healthlaw/perspectives/Managed/001129Difficulties.html> [hereinafter LANDAU] (explaining that the government defines medical necessity for several publically financed health insurance schemes, however the criteria utilized for plans provided through these programs are applicable only to those policies). Detailed analysis of Medicare coverage for mental health is beyond the scope of this paper, however for Original Medicare policyholders the barrier to care is whether the provider accepts assignment, or direct payment by Medicare on behalf of the beneficiary; see also CTRS. FOR MEDICARE & MEDICAID SERV., DEP'T HEALTH HUM. SERV., CMS PROD. NO. 10184, MEDICARE & YOUR MENTAL HEALTH BENEFITS (2014), <https://www.medicare.gov/Pubs/pdf/10184-Medicare-Mental-Health-Bene.pdf> (discussing that medical necessity for mental health care may be a less significant obstacle under Original Medicare compared to plans offered by private insurers (including Medicare Advantage plans, which are provided through private insurers and offer different benefits and limitations than Original Medicare).

<sup>38</sup> See Landau, *supra* note 37; See generally NAT'L ACAD. FOR STATE HEALTH POL., MEDICAL NECESSITY (Dec. 2013), <http://www.nashp.org/medical-necessity> (showing the then-current definitions each state applied for “medically necessary” as pertaining to Medicaid coverage and benefits).

<sup>39</sup> See Skinner, *supra* note 17, at s50.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* at s51 (stating that “the concern is that medical necessity is likely to remain uninterrogated in broader social terms...which means that patients with different coverage plans will continue to be subject to different outcomes from medical necessity decision making....”).

<sup>44</sup> See, e.g., Meredith Cohn, *Equal Coverage for Mental and Medical Health Remains an Issue, Studies Show*, THE BALTIMORE SUN, Apr. 3, 2015, <http://www.baltimoresun.com/health/bs-hs-mental-health-parity-20150403-story.html> [hereinafter Cohn] (exemplifying that a heroin user, after being turned away from a hospital by his insurance for not having a medically necessary reason to enter a detoxification program, overdosed and later died and citing a study conducted by the National Alliance for Mental Illness released this year, twice as many respondents to the NAMI survey claimed their mental health or substance use was not deemed medically necessary for coverage, twice the number of persons reporting denial of coverage for physical care needs).

and Addiction Equity Act (MHPAEA).<sup>45</sup> For instance, the MHPAEA sought to undo discrimination between mental health access and physical health access by requiring that the limitations on coverage for mental health services be no more restrictive than on physical health services.<sup>46</sup> However, the MHPAEA did not apply to all insurance plans: individual and small group plans as well as employer-funded plans in companies with less than fifty employees are excluded from the law's scope.<sup>47</sup> Similarly, the ACA expanded parity requirements to individual and small group plans, but retained opt-out options for non-governmental plans with fewer than a hundred employees and large self-funded non-federal government plans.<sup>48</sup>

Neither of the acts directly mandated that all health insurance plans cover mental health benefits, nor did either act substantively explain what would constitute sufficient coverage.<sup>49</sup> While several states, like Connecticut, have laws that require specific coverage for mental health, behavioral health, and/or substance abuse, the laws fall short of comprehensively addressing mental health.<sup>50</sup> This results in a patchwork of mandated coverage, some greater than others, which does little to ease access to coverage.<sup>51</sup>

Across the United States, mental health coverage is inconsistent and incomprehensive, to say nothing of those plans that provide no coverage at all.<sup>52</sup> Moreover, the National Alliance for Mental Illness (NAMI) conducted a survey and found that over twice as many mental health claims were denied as physical health claims.<sup>53</sup> A discrepancy exists for both purchasers of private insurance and purchasers of insurance on the federal marketplace.<sup>54</sup> Under parity, a "reasonable expectation" would be that the rates of denial would be roughly equal to each other.<sup>55</sup> Yet, mental health claims are denied

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<sup>45</sup> NAT'L ALLIANCE FOR MENTAL ILLNESS, A LONG ROAD AHEAD 1, 4-5 (2015), <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf> [hereinafter NAMI, A LONG ROAD AHEAD].

<sup>46</sup> *Id.* at 1, 4.

<sup>47</sup> *Id.* at 17.

<sup>48</sup> *Id.*

<sup>49</sup> See 42 U.S.C. § 300gg-26(3) (2010) (identifying required benefits but not what constitutes coverage).

<sup>50</sup> See NCSL, *supra* note 30. For example, Connecticut mandates coverage for mental or nervous conditions but does not regulate or ensure coverage for mental health conditions more broadly.

<sup>51</sup> See Skinner, *supra* note 17, at s51 ("...there is a great difference in states' medical necessity frameworks and appeals processes, especially under Medicaid, as some states explicitly include cost conditions, while others exceed minimum coverage requirements to include that which others consider elective and hence not strictly necessary.").

<sup>52</sup> See Skinner, *supra* note 17, at s51. See CTRS. FOR MEDICARE & MEDICAID, CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT, [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea\\_factsheet.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (last visited Nov. 30, 2015) (describing that the MHPAEA and ACA include exemptions for small group policies and self-funded policies, and did not apply to some aspects of Medicaid or the Children's Health Insurance Program).

<sup>53</sup> See NAMI, A LONG ROAD AHEAD, *supra* note 45, at 4.

<sup>54</sup> *Id.* at 4-5.

<sup>55</sup> *Id.* at 4.

twice as often as physical health claims, suggesting discrimination against mental health claims, mental health sufferers, or possibly both.<sup>56</sup>

The lack of a substantive federal definition for medical necessity, equally uniform criteria, or even a common substantive definition proscribed by a plurality of the states is problematic.<sup>57</sup> In this vacuum, insurance organizations have a free hand to adopt their own standards and little oversight in how they inform beneficiaries about these standards.<sup>58</sup> Many insurers utilize similar, albeit ambiguous, language in their definition. To paraphrase multiple insurers, medical necessity means health care services provided by a medical practitioner for the purposes of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that a) comport with generally accepted standards of medical practice (the likes of which are shaped in part by insurers who permit or omit coverage for medical practices); b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease; c) not provided as a convenience to the patient, physician, or provider; and d) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.<sup>59</sup> Insurer-determined criteria for what is and is not medically necessary in accordance to this definition are not necessarily accessible or even understandable to consumers.<sup>60</sup> Even where medical necessity is defined, the definition creates confusion for patients and health care providers alike.<sup>61</sup> Consumers are unable to make informed choices about their plans when purchasing them and equally deprived in their ability to assert their rights when faced with adverse determinations.<sup>62</sup>

## **B. Medical Doctors Are Not Always Psychiatrists**

Mental health illnesses may be the result of, the cause of, or in independent coexistence with physical illnesses.<sup>63</sup> A report from the Robert Wood Johnson Foundation found that 68% of adults with mental disorders also suffered from physical conditions, and 29% of adults with medical conditions also have mental disorders.<sup>64</sup> Despite such large

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<sup>56</sup> *Id.*

<sup>57</sup> *Id.* at 5.

<sup>58</sup> See NAMI, A LONG ROAD AHEAD, *supra* note 45, at 5.

<sup>59</sup> See, e.g., ANTHEM INS. CO., BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA I (2012), [https://www.anthem.com/ca/provider/fl/s0/t0/pw\\_a115176.pdf](https://www.anthem.com/ca/provider/fl/s0/t0/pw_a115176.pdf). This multi-faceted definition may impose a formulaic methodology towards treatment for mental illnesses, regardless of whether the formula works for the patient or not. Skinner, *supra* note 17, at s51.

<sup>60</sup> NAMI, A LONG ROAD AHEAD, *supra* note 45, at 5.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> BENJAMIN DRUSS & ELIZABETH WALKER, MENTAL DISORDERS AND MEDICAL COMORBIDITY 4, 6 (2011), [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf69438/subassets/rwjf69438\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1) [hereinafter DRUSS & WALKER].

<sup>64</sup> *Id.* at 4, 7. (explaining that among factors that worsened one or both medical and mental health conditions were socioeconomic indicators, such as low income or poor education and that such socioeconomic and environmental conditions correlate to the living experience for many marginalized groups); cf. GRANT, *supra* note 11.

populations with mental health issues, patients face significant challenges in having their needs adequately met.<sup>65</sup> Mental health illnesses often go untreated, undiagnosed, misdiagnosed, or otherwise receive inadequate care.<sup>66</sup> Where care is provided, it may come at high individual and societal costs that serve as barriers to access for sufferers.<sup>67</sup>

Absent a stronger guiding principle, medical necessity poses a challenge to addressing these sufferers' mental health needs. If coverage for mental health treatment is linked to the physical injury or illness, the system is dependent on the physical care provider and the claim reviewer agreeing that there is a connection.<sup>68</sup> Physical care providers and claim reviewers are not necessarily the most capable persons to make such determinations due to lack of familiarity or expertise in mental health conditions.<sup>69</sup> Basing medical necessity determinations on a physical injury or illness works to deny valid mental health claims for want of more accurate diagnoses.<sup>70</sup>

### **C. Inadequate Enforcement Of Parity Laws Enables Discrimination**

The issue of enforcement of the MHPAEA and ACA for mental health parity is complicated, involving the Department of Labor, Department of Health and Human Services, and states themselves.<sup>71</sup> However, actual enforcement and monitoring of compliance is suspect, with 25% of health insurance plans offered through exchanges that fail to comply with federal parity rules.<sup>72</sup> Even where states have superior parity rules, access to vital mental health care is being denied to sufferers who otherwise have health insurance coverage for their illness or substance abuse disorders.<sup>73</sup> The confusing multi-layered enforcement structure of the ACA and MHPAEA contributes to laws

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<sup>65</sup> See generally NAMI, *A LONG ROAD AHEAD*, *supra* note 45.

<sup>66</sup> DRUSS & WALKER, *supra* note 63, at 9-10.

<sup>67</sup> *Id.* at 11-12.

<sup>68</sup> *Cf.* Skinner, *supra* note 17.

<sup>69</sup> DRUSS & WALKER, *supra* note 63, at 11 (explaining that the confusion is mutually applicable to mental health practitioners who may misdiagnose a physical condition and that physical conditions and mental health conditions also have broad overlap of somatic symptoms that lends an untrained eye to misdiagnose a mental health condition or conclude that the patient's mental health condition is not related to a physical injury or illness).

<sup>70</sup> *Id.* at 10-11.

<sup>71</sup> NAMI, *A LONG ROAD AHEAD*, *supra* note 45, at 13 (explaining that states are the primary authority for implementation, though the Department of Labor is responsible for enforcing parity in self-insured employee plans and the Department of Health and Human Services has authority in Medicare and Medicaid plans in the absence of the states); see also Kathleen Noonan & Stephen Boraske, *Enforcing Mental Health Parity Through the Affordable Care Act's Essential Health Benefit Mandate*, 24 *ANNALS OF HEALTH L.* 252 (2012) [hereinafter Noonan & Boraske] (providing a compelling analysis on the inadequate enforcement mechanisms and monitoring procedures of the APA and MHPAEA, contributing to the overall disparity the laws purported to redress).

<sup>72</sup> Press Release, Johns Hopkins University, *Despite Federal Law, Some Exchange Plans Offer Unequal Coverage for Mental Health* (Mar. 2, 2015), <http://www.jhsph.edu/news/news-releases/2015/despite-federal-law-some-insurance-exchange-plans-offer-unequal-coverage-for-mental-health.html> (explaining that the study used looked at two state exchanges—a large state exchange and small state exchange – and though while not indicative of a national trend, the results warrant “a more comprehensive study...to see if this is a systemic problem...”).

<sup>73</sup> Cohn, *supra* note 44.

that are not particularly well enforced, and to the detriment of those who rely on the state for protection.<sup>74</sup> For starters, the ACA and MHPAEA preserve the practice that medical necessity determinations for mental health care are made at the discretion of primary care physicians and the insurer.<sup>75</sup> Medical necessity, defined ambiguously in policies covering mental health needs, may not cover the particular needs for particular communities like the transgender persons mentioned earlier in this paper.<sup>76</sup> Medical necessity determinations based on physical injury and illness are premised on persons with “traditionally gendered bodies” which has the effect of hindering “transsexuals’ access to care.”<sup>77</sup> The conventional benefits network is designed to serve a community composed of male and female identifications. A transgender person with mental health issues faces an obstacle within the insurance scheme itself, identifying as one sex or gender, but being born another.<sup>78</sup> Little recourse is available to such a person when the physical needs of their birth-bodies do not correspond to a mental health need of their gender-identity.<sup>79</sup>

Though designed to afford greater access to all forms of health care, the MHPAEA and ACA do little to clear the uncertainty about whether a person’s mental health needs are medically necessary.<sup>80</sup> This is functional discrimination in the face of federal and state law.<sup>81</sup> The insurance providers wield immense power to determine whether a mental health need is medically necessary, what specific conditions must be met to warrant coverage, and, if all conditions are met, what specific coverage may be provided.<sup>82</sup> As a consequence, arguably arbitrary decisions that are vulnerable to capricious and even draconian reasoning, leaving whole populations in a state of insecurity as to whether they are truly ever covered.

Insurance providers are, in the end, business enterprises, and have different priorities and goals than those of a patient suffering from a mental health illness.<sup>83</sup> Whatever generalized gains such austerity creates, they come at the expense of persons with mental health illnesses. Continued deference to private, market-oriented entities in determining

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<sup>74</sup> NAMI, *A LONG ROAD AHEAD*, *supra* note 45, at 13.

<sup>75</sup> See Skinner, *supra* note 17, at s53.

<sup>76</sup> *Id.* (stating that transgender person are one of the most vulnerable communities).

<sup>77</sup> Skinner, *supra* note 17, at s53. “Transsexuals” is not necessarily the same as “transgender” and these two groups of people may be treated independently; however, the risk of adverse medical necessity determinations affects both groups similarly. GLAAD, <http://www.glaad.org/reference/transgender>.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* at s52-4.

<sup>80</sup> Compare Aubrey Chamberlin, Note, *Stop the Bleeding: A Call for Clarity to Achieve True Mental Health Parity*, 20 WIDENER L. REV. 253, 267 (2014) (discussing the need for the Health Department to clearly define mental illness for insurance coverage purposes) with Joni Roach, Note, *Discrimination and Mental Illness: Codified in Federal Law and Continued By Agency Interpretation*, 2016 MICH. ST. L. REV. 269 (2016) (discussing the discrimination that results from poorly defining mental illness).

<sup>81</sup> *Id.*

<sup>82</sup> Rosenbaum, *Medical Necessity*, *supra* note 23.

<sup>83</sup> See Skinner, *supra* note 17, at s50.

the medical needs of a patient skews the system away from public and personal health and towards the financial incentives of corporations, validating “cherry-picking” practices for who and what will be covered, to what extent, and in what manner.<sup>84</sup>

## II. MULTI-DIMENSIONS TO MEDICAL NECESSITY

The Substance Abuse and Mental Health Services Administration identifies five components to the insurer’s calculus for medical necessity.<sup>85</sup> These dimensions include: (1) the scope as determined in the contract, (2) the standards of professional practice, (3) patient safety and setting of the intervention, (4) medical service (e.g. service a medical need), and (5) cost-effectiveness of the particular treatment.<sup>86</sup> These broad categories are extracted from diverse schools of thought and industry practice, reflecting the debate within both the academic and professional community as to what should and should not constitute criteria.<sup>87</sup> The exact interplay between these dimensions is variable and subject to any number of sub-factors, ultimately resulting in a determination that best suits the interests of the insurance provider.<sup>88</sup>

Insurance providers do not often disclose to the patient or the general public their process for determining medical necessity.<sup>89</sup> Consumers implicitly must struggle to know what these plans actually cover and, critically, what they do not.<sup>90</sup> In addition, state regulators do not regularly examine the marketing material of insurance companies, providing

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<sup>84</sup> Cf. Rosenbaum, *Medical Necessity*, *supra* note 23. There is no fault in a private health insurance provider factoring cost into their calculus, for the very reason that they are a private enterprise. However, the population health goals of public health are better served when the objectives for reaching those goals are more oriented towards the physical and health needs of natural persons.

<sup>85</sup> Substance Abuse and Mental Health Serv. Admin., Dep’t Health Hum. Serv., *Medical Necessity in Private Health Plans* HHS PUBL’N NO. (SMA) 03-3790 1, 13 (2003) [hereinafter SAMHSA, *Medical Necessity*]. The report begins by stating that, for lack of a uniform federal or state-originating definition of medical necessity, the insurers themselves in their plans and policyholder agreements often define the term and set its criteria.

<sup>86</sup> *Id.*

<sup>87</sup> *Id.* at 7-13 (discussing academic debate as to what is medically necessary and industry practice-definitions for medical necessity, and concluding that deference to multi-dimensional industry practice-definitions is ingrained).

<sup>88</sup> See generally SAMHSA, *Medical Necessity*, *supra* note 85; See also *supra* note 59 and accompanying text.

<sup>89</sup> SAMHSA, *Medical Necessity*, *supra* note 85, at 7-10. But see 29 C.F.R. § 2590.712(d) (2010) (stating that the criteria for medical necessity determinations and reasons for denial must be made available to beneficiaries *at their request* in group health plans) (*emphasis added*). See also Dep’t of Labor, *FAQs About Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation* (2013), <http://www.dol.gov/ebsa/pdf/faq-aca17.pdf> (stating that upon individual request, beneficiaries must have reasonable access to documents pertaining to an individual claim, including “documents of a comparable nature with information on medical necessity criteria....”).

<sup>90</sup> See Cohn, *supra* note 44. Consumers of health plans do not always read the fine print of their selected plans, and are rather influenced by marketing materials proffered by the insurer. See also NAMI, *A LONG ROAD AHEAD*, *supra* note 45, at 11-2 (“When selecting health plans available in State Marketplaces, consumers and family members generally do not have access to information needed to make informed decisions.”).

ample opportunity for insurance companies to mislead consumers.<sup>91</sup> Patients with mental health needs may be discriminated against and have no means to seek redress, having never fully known what their benefits were.

### **A. Mental Health Sufferers Need and Rely On Protection**

The ACA listing mental health as an essential benefit may be a win for mental health rights; however, this alone will not end discrimination against mental health sufferers. The ACA also sanctions the “de facto” definitions of medical necessity used by industry that largely omit reference to the “broad range of conditions” that may give rise to mental health needs.”<sup>92</sup> This past deference to insurers hamstrings the patient-centered ideals of the ACA and MHPAEA regarding medical necessity.<sup>93</sup> The legislation still permits insurers to exclude many cognizable conditions from treatment or restrict treatment for non-health-related reasons.<sup>94</sup> Further, the laws retain the insurers’ role in designating covered and non-covered treatments without according any discretion to providers or patients to make “individualized coverage determinations within broader benefit classes.”<sup>95</sup> Antithetically, the parity laws themselves “tolerate differences in approach to coverage” within the medical necessity context, to the practical and discriminatory detriment of mental health.<sup>96</sup>

Insurers use medical necessity formulaically, but access to mental health benefits cannot be arithmetic.<sup>97</sup> The challenge is ensuring that “the ACA’s antidiscrimination protections for benefits” are not hindered by rigid criteria modeled largely on nondescript guidelines for the physical health needs of the general public.<sup>98</sup> Instead of conceptualizing medical necessity as what is medically appropriate for a specific individual in a particular case,

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<sup>91</sup> See Cohn, *supra* note 44.

<sup>92</sup> See Rosenbaum, *Medical Necessity*, *supra* note 23. Rosenbaum uses the example of speech therapy to treat a stroke victim as something which would be covered, but the same therapy to treat an individual with cerebral palsy is deniable if the therapy is a “condition”, and less clearly an illness or injury.

<sup>93</sup> See Skinner, *supra* note 17, at s53. Skinner address Rosenbaum and reiterates her claim that the ACA does not address properly mental health conditions, opening a coverage gap for insurers to exploit. Skinner extends the argument further, stating that even had the ACA included “conditions” in its working definition of medical necessity, the term itself remains highly variable and affords too much discretion for insurers to determine what is and is not a condition.

<sup>94</sup> SARA ROSENBAUM, *INSURANCE DISCRIMINATION ON THE BASIS OF HEALTH STATUS* 13, 15 (O’Neill Inst. Nat’l & Global Health L. ed., 2009) [hereinafter ROSENBAUM, *HEALTH STATUS*]. Rosenbaum analogizes that the equivalent exclusion for physical health would be to deny coverage to certain cancers and specification as to which treatments for cancer would be approved, regardless of individual needs and variation. In other laws that purportedly extend coverage for mental health and disabilities, the laws have not been interpreted as extending to “reaching the content” of coverage and provide little legal remedy even to persons for whom the laws are designed to protect.

<sup>95</sup> *Id.*

<sup>96</sup> *Id.* See also Joni Roach, Note, *Discrimination and Mental Illness: Codified in Federal Law and Continued By Agency Interpretation*, 2016 MICH. ST. L. REV. 269, 299-300 (2016) [hereinafter Roach].

<sup>97</sup> See Skinner, *supra* note 17, at s51.

<sup>98</sup> *Id.*

defining medical necessity in regards to accessing benefits effectively makes medical necessity a bar set by parties not privy to the patient and his or her needs.<sup>99</sup>

Mental health needs are often less clear in their scope and are supported less by evidence that a particular benefit can improve upon a particular mental illness.<sup>100</sup> The challenge in addressing this difficulty is potentially a reason for why health insurance does not default to comprehensively covering mental health, or why some plans stopped covering mental health needs following the passage of parity laws.<sup>101</sup> On the other hand, conditions that are not arduous when placed on physical health treatments may prove prohibitive for mental health treatments, giving insurers a lawful means to “limit” the “types of care” they provide while nominally adhering to parity by holding mental health benefits to the same standards as physical health benefits.<sup>102</sup>

## **B. Asymmetric Information Is Hindering Informed Consumer Purchasing**

Consumers need to know the calculus insurers make in determining medical necessity in order to make informed choices; however, this data is not always readily provided.<sup>103</sup> Moreover, even where the date is provided, there is a risk that people with mental health needs may not be well positioned to utilize it unless the information is adequately and suitably understandable from a consumer’s perspective.<sup>104</sup> Though insurers know how, when, and for what medical necessity determinations will be made, consumers are left in a state of insecurity as to what their mental health benefits really are and under what terms they have access to them.<sup>105</sup> In response to calls for transparency, insurers often

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<sup>99</sup> *Id.*

<sup>100</sup> SAMHSA, *Medical Necessity*, *supra* note 85, at 14-5. Notably, not every mental illness can be treated such that there is significant improvement in the patient’s condition, however some insurers may treat mental illnesses like physical injuries which can be fully recovered from and less like chronic conditions that require continual treatment and therapy. Compare Rosenbaum, *Medical Necessity*, *supra* note 23 (noting that “conditions” includes mental health illnesses as well as physical illnesses for which therapy may slow or prevent further degradation but for which treatment may not yield curative status) with PRIORITY HEALTH MANAGED BENEFITS, INC., MEDICAL NECESSITY AND LEVEL OF CARE DETERMINATION CRITERIA 3 (2014), <https://www.priorityhealth.com/provider/manual/auths/bh/~/-/media/documents/bh/bh-medical-necessity-criteria.ashx> (“Mental illness is defined as a psychiatric disorder that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate therapy.”).

<sup>101</sup> See Noonan & Boraske, *supra* note 71 (“Some insurance plans report they dropped their [mental health and substance use] benefits to avoid compliance with the MHPAEA.”).

<sup>102</sup> SAMHSA, *Medical Necessity*, *supra* note 85, at 13.

<sup>103</sup> See Ollove, *supra* note 19. See also NAMI, A LONG ROAD AHEAD, *supra* note 45, at 4. Beneficiaries denied mental health treatments due to medical necessity not being met “often complain that...treatment is denied...arbitrarily and without reasonable explanation.”

<sup>104</sup> See NAMI, A LONG ROAD AHEAD, *supra* note 45, at 7 (“The common use of medical necessity criteria and other utilization management tools to limit care for mental illness is particularly concerning because it is very difficult if not impossible for consumers and family members to find information on criteria used to make such decisions.”).

<sup>105</sup> *Id.* at 11-12. The ACA requires insurers to publish a Summary of Benefits, but a summary does not provide the fine details as to what precisely is included or excluded from mental health coverage. Moreover, such publications are easily manipulated into advertisements and so less likely

make broadly framed guidelines available regarding medical necessity determinations.<sup>106</sup> The quality of these guidelines, in terms of their depth and comprehensiveness, varies considerably.<sup>107</sup> Nevertheless, most guidelines determine medical necessity based on whether the treatment in question (1) is the treatment for the diagnosed condition that comports to the standards of good medical practice, (2) is required for remedying the condition and not purely for the convenience of the patient or others, and (3) is appropriate for the level of care needed.<sup>108</sup>

A prudent consumer may take the time to read a tome on how medical necessity determinations may be made generally, but the gist of such a review is that the insurer will try to first fit the patient's needs into a pre-measured box of services, regardless of whether those needs are best served in that box.<sup>109</sup> Some guidelines recognize that there may be exceptional cases to their own rules, but this alone does not inform a consumer as to what may and may not be exceptional.<sup>110</sup> In addition, the guidelines may not reflect the criteria that actually govern a patient's plan, as several guidelines indicate.<sup>111</sup> Consequently, the utility of broadly framed guidelines is lessened since they are neither predictive nor truly guiding, affording the insurer room to make the medical necessity determination it prefers over what the patient may actually need.<sup>112</sup> This paper does not suggest that discrimination or denial of coverage will always occur; however, the defective system consumer's currently rely upon gives rise to risk for discrimination and denial of coverage, particularly for some vulnerable communities.<sup>113</sup>

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to state limitations and exclusions to a policy that may hurt consumer purchasing. *See generally* Cohn, *supra* note 44.

<sup>106</sup> For instance, the "Medical Necessity Criteria Guidelines" for Magellan Health, Inc., is approximately 177 pages long and fairly comprehensive. Important policy details may require such breadth of writing, but it may make scrutiny of those details unlikely. MAGELLAN HEALTH, INC., MEDICAL NECESSITY CRITERIA GUIDELINES (2015), <https://www.magellanprovider.com/media/1771/mnc.pdf>. On the opposite end, the guidelines for Priority Health are 7 pages long and couched in inflexible terms and conditions for when mental health benefits may be accessed. PRIORITY HEALTH MANAGED BENEFITS, INC., MEDICAL NECESSITY AND LEVEL OF CARE DETERMINATION CRITERIA 3 (2014), <https://www.priorityhealth.com/provider/manual/auths/bh/~media/documents/bh/bh-medical-necessity-criteria.ashx>.

<sup>107</sup> *Id.*

<sup>108</sup> *See, e.g.*, CIGNA HEALTH AND LIFE INS. CO., CIGNA STANDARDS AND GUIDELINES/MEDICAL NECESSITY CRITERIA GUIDELINES 7 (2015), <http://apps.cignabehavioral.com/web/basic/site/media/consumer/educationAndResourceCenter/medicalNecessityCriteria.pdf>.

<sup>109</sup> *See, e.g.*, ANTHEM INS. CO., BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA 5 (2012), [https://www.anthem.com/ca/provider/fl/s0/t0/pw\\_a115176.pdf](https://www.anthem.com/ca/provider/fl/s0/t0/pw_a115176.pdf).

<sup>110</sup> *See, e.g.*, MAGELLAN HEALTH, INC., MEDICAL NECESSITY CRITERIA GUIDELINES I-II (2015), <https://www.magellanprovider.com/media/1771/mnc.pdf>.

<sup>111</sup> *See, e.g.*, ANTHEM INS. CO., BEHAVIORAL HEALTH MEDICAL NECESSITY CRITERIA I (2012), [https://www.anthem.com/ca/provider/fl/s0/t0/pw\\_a115176.pdf](https://www.anthem.com/ca/provider/fl/s0/t0/pw_a115176.pdf).

<sup>112</sup> *See* Roach, *supra* note 96, at 291-2 ("Without more guidance from the HHS...disparate treatment will likely continue at the expense of mental-health-treatment access").

<sup>113</sup> *Id.* *See, e.g.* Skinner, *supra* note 17, at s53-4.

### III. PRIVATE ENFORCEMENT OF MENTAL HEALTH RIGHTS

Private enforcement of one's mental health rights does not readily favor the beneficiary of an insurance policy.<sup>114</sup> The ACA's role in providing fairness in the system is intended to ensure that the patient's rights are protected, in part by requiring "effective" internal appeals processes within the insurance policy as well as external review processes that include consumer protections.<sup>115</sup> The value of the ACA in regards to reforming medical necessity determinations lies in its apparent creation and reinforcement of additional space for litigation and adjudication.<sup>116</sup>

Trust in the internal review and the external review processes is not to be placed naively. Internal review processes may meet a standard of "effectiveness," yet remain highly variable given the multi-dimensional platform from which medical necessity is determined.<sup>117</sup> The external review process is presumed valid, producing "real" or "true" medical necessity determinations, because of perceptions of independence.<sup>118</sup> But the existence of appeals processes do not guarantee that the reviewing body is free of "problematic conceptions" that may prejudice the outcome of such reviews for or against the patient.<sup>119</sup>

External review of the substance of medical necessity determinations would be as beneficial as ensuring proper procedure in making those determinations.<sup>120</sup> If the consumers of a mental health coverage policy choose to seek relief in the court system, their chance of success is uncertain. For example, in *Jones v. Kodak Medical Assistance Plan*, the plaintiff brought suit to claim substance abuse and mental health benefits under the Employee Retirement Income Security Act, having been denied those benefits by her insurer for treatment the insurer deemed "unnecessary." The Tenth Circuit decided that the unpublished criteria for determining medical necessity by an administrator of managed care are not reviewable by the court.<sup>121</sup> However, the court held that the insurer had full discretion to make such determinations.<sup>122</sup> Moreover, because the insurer's

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<sup>114</sup> SAMHSA, *Medical Necessity*, *supra* note 85, and accompanying text.

<sup>115</sup> *See Skinner*, *supra* note 17, at s56.

<sup>116</sup> *Id.* at s51.

<sup>117</sup> *Id.* at s56.

<sup>118</sup> *Id.*

<sup>119</sup> *See Skinner*, *supra* note 17, at s56. Trust in an outside organization's review borders on naïve as "...it is precisely *because* of their perceptions as impartial that groups seeking to ensure that ACA antidiscrimination provisions, as well as the pursuit of ethical and efficacious health care more generally, must remain attuned to the unstated normative dimensions of these bodies' decision-making processes."

<sup>120</sup> *Id.*

<sup>121</sup> 29 U.S.C. §1001-1461 (1974). *See Jones*, 169 F.3d, at 1290.

<sup>122</sup> *Jones*, 169 F.3d, at 1292. The court reasoned that reliance on unpublished criteria was neither arbitrary nor capricious, and that it was not expected to provide such detailed information to beneficiaries. *See also SAMHSA, Medical Necessity*, *supra* note 85, at 20 ("[*Jones*]... is the leading case for the proposition that insurers have the power to contractually limit the types of necessary treatments they will cover by building their guidelines directly into the structure of the plan documents. As a result, *Jones*... contained no medical necessity definition *per se* but instead a provision construed by the court as limiting treatment to the guidelines used....").

discretion preempted the decisions made by the plan administrators or health care providers, the plaintiff had no right to appeal.<sup>123</sup> Whatever injury to mental health rights and treating mental health needs these extra-judicial systems may cause, many courts are reluctant to look past the contract's vestment of discretion in the insurer to even see if there was true mutual assent and fair dealing.

Pursuing relief through the courts is both a privilege and luxury bought by having a valid cause of action, one's social standing, and access to resources.<sup>124</sup> Even where a claimant has the time and resources to litigate, courts have regularly enforced the terms of policy including specific exclusions to treatments.<sup>125</sup> Courts will often limit its review of the policy to whether the decision was made arbitrarily or capriciously.<sup>126</sup> As shown in subsequent cases, court's defer to the insurer's decision so long as there is some process for review and "substantial evidence" to support the conclusion.<sup>127</sup> Substantial evidence need not be a preponderance, but merely "more than a scintilla" to pass.<sup>128</sup> Even worse from the patient's perspective, cause for denial does not have to be good, logical, or altogether reasonable.<sup>129</sup> It is exceedingly difficult for a claimant to press for their mental health benefits when the court accepts that the insurer's "full discretionary authority" permits discriminatory exclusions and limitations.<sup>130</sup> When the exercise of that discretion need only be procedurally regular, and not the best for the patient, private enforcement of mental health rights may be near impossible.<sup>131</sup>

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<sup>123</sup> See ROSENBAUM, HEALTH STATUS, *supra* note 94 and accompanying text.

<sup>124</sup> Jenny Gold, *Health Insurers Face Little Enforcement of Federal Mental Health Parity Law*, NAT'L PUB. RADIO (Jul. 29, 2015), <http://www.npr.org/2015/07/29/427464632/health-insurers-flout-federal-parity-law-for-mental-health-coverage>. The subject of this news report filed a lawsuit on behalf of his son, who was denied mental health treatment for lack of medical necessity; New York law gives a cause of action, whereas the federal law does not. Additionally, bringing a lawsuit is "a costly and time-consuming endeavor" and most consumers do not know they even have legal protection.

<sup>125</sup> See *infra* notes 127-128.

<sup>126</sup> SAMHSA, *Medical Necessity*, *supra* note 85, at 20. In the 2003 report, a little over half of decisions regarding the correctness of a medical necessity determination were in favor of the insurer. This may reflect "the merits of their decisions" or "the difficulties claimants encounter in challenging a medical necessity denial." The standard of review courts approach such cases with is the minimal level of scrutiny that the insurer's determination was reasonable or not otherwise arbitrary or capricious, in light of the policy.

<sup>127</sup> See, e.g., *Carlo B. ex rel. C.B. v. Blue Cross Blue Shield of Mass.*, No. 2:08-CV-0059 BSJ, 2010 WL 1257755, at \*5 (D. Utah Mar. 26, 2010) (concluding that although the defendant's denial of coverage "...appears to have taken a more draconian view of what was 'medically necessary'... it cannot fairly be said that [the decision] was 'not grounded on any reasonable basis' and was therefore arbitrary and capricious.").

<sup>128</sup> *Id.* at \*3. This standard is exceptionally permissive of claim denials and undermines the concept of substantiality. Substantial need not be a preponderance, but a mere scintilla of evidence would allow basically any evidence – regardless of support or merits, quantity or quality – to pass the court's test.

<sup>129</sup> *Id.* at \*5.

<sup>130</sup> *Id.*

<sup>131</sup> *Id.* at \*3.

The mental health sufferer seeking a reversal of an adverse medical necessity determination carries the burden of proof to show that the decision was arbitrary or that the court did not consider all the evidence.<sup>132</sup> The insurer holds the substance of the decision-making process and other potential evidence that may require discovery to obtain. Thus, when the courts are unwilling to consider substance on par with process, consumers face a challenging hurdle to proving that the decision was arbitrary.<sup>133</sup> This trend in the courts to enforce the terms of policies that define medical necessity in circumscribed language, even if it results in denial for mental health treatment, is a significant obstacle for consumers.<sup>134</sup>

The current system for access to mental health benefits and medical necessity favors mechanical application of specific treatments to specific issues, with little transparency for consumers.<sup>135</sup> Deference to contracts presupposes that the consumer has all the relevant information as well as the tools to understand the scope of their insurer's discretion.<sup>136</sup> The definitions the insurance industry use go "beyond assessing whether treatment meets a professional standard of care" and enable the insurer to select from whichever treatments – if any – it will cover that are "ostensibly" appropriate, the convenience or preference of the consumer and primary care provider notwithstanding.<sup>137</sup> Discrimination may not always be intentional, but a system that permits broad exclusions and discretionary choices for some benefits cannot help but discriminate.<sup>138</sup>

#### IV. DISCUSSION ON PROPOSALS FOR CHANGE

There is vibrant literary and scholastic discussion about what components should be factored into medical necessity definitions and determinations. Some proposals err to reinforcing current industry-practice, which favors empirical and evidentiary grounds, while reformers call for more comprehensive and individual-patient-centric approaches that explicitly call for greater access to mental health care and behavioral treatments.<sup>139</sup> Proposals to improve medical necessity definitions and determinations are not mutually exclusive: industry-practice is not designed or intended to be automated and without

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<sup>132</sup> SAMHSA, *Medical Necessity*, *supra* note 85, at 10, 20, 26-7.

<sup>133</sup> *Id.*

<sup>134</sup> *Id.* See also Skinner, *supra* note 17, at s54. The politics of defining medical necessity plays out at multiple levels, any of which may find mental health or other needs not specifically covered and stymie or curtail treatment. This raises the concern that medical necessity determinations may be circumscribed by narrowly defined terms that do not act with the necessary breadth and flexibility to provide necessary care and treatment.

<sup>135</sup> ROSENBAUM, HEALTH STATUS, *supra* note 94, at 17.

<sup>136</sup> *Id.*

<sup>137</sup> SAMSHA, *Medical Necessity*, *supra* note 85, at 20.

<sup>138</sup> Roach, *supra* note 96, at 288-292, 310.

<sup>139</sup> SAMSHA, *Medical Necessity*, *supra* note 85, at 7-10. The SAMSHA report provides a fair airing of the principle schools of thought and their contemporary proponents. While each school varies in substance to a degree, the report identifies that they all proffer a definition for medical necessity which 1) does not permit every intervention at all times, 2) is multi-dimensional, considering factors such as but not limited to convenience, efficaciousness, and cost of a treatment, and 3) is broad in scope sufficiently to extend coverage beyond mere diagnosis and treatment of an illness or injury and include treatment for improving and maintaining functionality.

consideration, and expansive approaches still find grounding in empirical evidence for effectiveness.<sup>140</sup> Within this teeter-tottering lies a balance between providing the care people with mental health needs require and providing that care reasonably.

A starting point for this discussion is to quickly dispel convention and generalized “across-the-board” conclusions when it comes to treating persons with mental health needs.<sup>141</sup> Not every cause for depression will map neatly to a physical injury or illness, especially for persons who represent unique or particular health needs and considerations (e.g. transgender persons).<sup>142</sup> The institution-deferred, multi-dimensional model permits abstract definitions of medical necessity that do not sufficiently contextualize a particular medical need, presenting an acutely challenging issue in the context of mental health.<sup>143</sup>

There are several approaches, discussed below, which policymakers may consider in mitigating or resolving the inequity and de facto discrimination: (1) improving transparency and closing the information gap regarding medical necessity criteria, (2) strengthening the government’s role in defining medical necessity and stronger enforcement of parity laws, (3) overcoming judicial reluctance to look past procedure in reviewing medical necessity determinations and health insurance policies, and (4) improving consumer-driven health care reform. This paper offers an assessment of each in turn.

### **A. Greater Transparency in Medical Necessity Criteria**

The low-hanging fruit for improving mental health access under the current medical necessity system could be improving transparency in the decision-making process.<sup>144</sup> Specifying criteria to consumers gives them the benefit of holding insurers accountable to their own terms and additionally provides consumers with specific, but critical, information regarding what factors may have gone into denial of care.<sup>145</sup>

For example, if cost were a significant factor in denial, the burden would be rightly placed on the insurer to justify how the cost consideration of a treatment outweighed the possible benefits to the patient’s health and wellbeing.<sup>146</sup> Similarly, the insurer should have to defend its decision if concluding the scope of coverage did not extend

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<sup>140</sup> *Id.* at 9-10.

<sup>141</sup> *Id.* at 10.

<sup>142</sup> ROSENBAUM, *HEALTH STATUS*, *supra* note 94, at 17. While such treatment “may ultimately serve population-wide interests” it ignores to their detriment small but discrete groups who have either complex or unconventional conditions and health needs.

<sup>143</sup> Skinner, *supra* note 17, at s57.

<sup>144</sup> See, e.g., Skinner, *supra* note 17, at s58; NAMI, *A Long Road Ahead*, *supra* note 45, at 11-4 (recognizing the problems faced by consumers in acquiring, and interpreting, information about their coverage and recommending requiring publishing the clinical criteria insurers use for determining medical necessity, and for plans to provide clear and understandable information on benefits and make such information easily accessible).

<sup>145</sup> See SAMHSA, *Medical Necessity*, *supra* note 85, at 10 (providing the calculus to consumers may also give them a means to challenge a denial within the internal review process and through the courts and shift the burden onto the insurer to justify a denial).

<sup>146</sup> SAMHSA, *Medical Necessity*, *supra* note 85, at 10.

to a particular treatment or illness, affording the policyholder a forum to press for their mental health rights and protections.<sup>147</sup> Decisions – even justified decisions – generated opaquely disservice those affected by them.

This step would not require significant alteration of the current law or rules; however, regulators would need to diligently ensure compliance and increase enforcement efforts. Effective compliance and enforcement requires that the criteria for medical necessity be made available “upon request” by the beneficiary, while reasons for denial must likewise be provided “on request or as otherwise required.”<sup>148</sup> The federal and state governments could also require that these reasons always be provided and could likely stipulate that the information be provided expediently and in consumer-friendly terms.<sup>149</sup> State statutes may require giving the medical necessity criteria in advance; however, the federal agencies should consider amending the Final Rule to require criteria always be provided, not just when requested.

## **B. Stronger Government Roles in Determining Medical Necessity**

In light of the lengthy legislative process and the American political demography, seeking administrative action may better help mental health sufferers than proposing a new statute.<sup>150</sup> While a cumbersome process, federal agencies could take measures to better ensure that mental health needs are addressed.<sup>151</sup> The ACA enacted a floor for benefits with mechanisms to increase accessibility and affordability for those benefits (including mental health benefits) out of a principle of basic entitlement; disparate, state-driven or consumer-driven models would not have the consistency, reach, or leverage to accomplish the same.<sup>152</sup>

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<sup>147</sup> See *Craft v. Health Care Serv. Corp.*, 84 F. Supp. 3d 748, 751, 753 (N.D. Ill. 2015) (determining that categorical exclusions for a mental health treatment are invalid where such limitations are not demonstrable for comparable physical health treatments); *Rea v. Blue Shield of Cal.*, 226 Cal. Rptr.3d 823, 838 (Cal. Ct. App. 2014) (denying insurer’s claim that it was not obligated to provide all treatments which may be medically necessary for mental health conditions when no analogous treatment existed for physical health conditions); *Harlick v. Blue Shield of Cal.*, 686 F.3d. 699, 721 (9th Cir. 2012) (determining that the scope of coverage mandated by the California Mental Health Parity Act required insurer to cover residential care).

<sup>148</sup> 42 U.S.C. § 300gg-26(a)(4) (2010).

<sup>149</sup> Cf. NAMI, *A Long Road Ahead*, *supra* note 45 (using graphs to show that there are a still a handful of people do not know why they are denied coverage).

<sup>150</sup> See Rosenbaum, *Medical Necessity*, *supra* note 23 (criticizing the Department of Labor’s Final Rule on interpreting the parity requirements of the ACA for excluding “conditions” from the necessary components to medical necessity definitions); Skinner, *supra* note 17, at s55-7 (discussing the role that the Department of Health and Human Services could play in oversight and setting national guiding principles for medical necessity).

<sup>151</sup> Rosenbaum, *Medical Necessity*, *supra* note 23; Skinner, *supra* note 17, at s55-7.

<sup>152</sup> Roach, *supra* note 96, at 309 (“...by enacting the ACA and requiring that all insurance plans within its scope offer the [essential health benefits], Congress has made it clear that it intends to manage and improve health insurance at the federal level”). See also NCSL, *supra* note 30. Were the United States to have a health system that places the burden on states to create uniform and equitable mental health service standards or vulnerable individuals to negotiate in a market system that fosters their vulnerability (as now-current proposals to repeal-and-replace the ACA suggest), the

Enforcing compliance to current parity law could provide another avenue for pursuing accountable and transparent insurance practices.<sup>153</sup> The ACA and MHPAEA create a convoluted and multilayered oversight framework, making it difficult to determine who enforces compliance.<sup>154</sup> Monitoring must be streamlined for persons to bring a cause of action under the relevant statute.<sup>155</sup> The Department of Health and Human Services and the Department of Labor could take a more active role, including partnering more with state regulators to ensure compliance with state parity laws, with a careful eye towards the information (and misinformation) being issued to consumers.<sup>156</sup>

However, there is a wrinkle in the administrative approach: such reform would necessitate an active civil society lobbying for a change palatable to society.<sup>157</sup> Advocacy groups representing the more marginalized members of society must “apply pressure” on the agencies to ensure medical necessity guidelines do not work to exclude their constituencies.<sup>158</sup> At the same time, the terms which are sought for inclusion in the federal rules for medical necessity – such as conditions, or similar mental health-related terms – must also come as an acceptable component reflecting a “commitment to a broader medical ethic” that actively pursues better, not merely cheaper, care.<sup>159</sup> Engagement by civil society across all levels of government may not make medical necessity any less “messy” in the short-term, but it will give voice and representation to those who have none and may contribute towards a more uniform, comprehensive, and principled definition for medical necessity.<sup>160</sup>

### C. Reassessing Deference to the Contract

The terms of policy contracts narrowly structure coverage for policyholders, and accessing even those circumscribed benefits can be challenging for persons with mental health needs.<sup>161</sup> Industry’s practices are “inherently discriminatory” by design, with

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likely beneficiaries would be those who already have sufficient resources to ensure their health at the expense of those who do not.

<sup>153</sup> Rosenbaum, *Medical Necessity*, *supra* note 23; Skinner, *supra* note 17, at s55-7. See NAMI, *A Long Road Ahead*, *supra* note 45, at 13.

<sup>154</sup> NAMI, *A Long Road Ahead*, *supra* note 45, at 13.

<sup>155</sup> NAMI, *A Long Road Ahead*, *supra* note 45, at 13. See also Noonan & Boraske, *supra* note 101, at 270, 275-76. (identifying that the MHPAEA does not itself create any architecture for enforcement, and agencies charged with oversight and compliance sought only ‘good faith’ adherence to the law, a fairly low threshold. However the ACA and the Final Rule give some oversight to the Department of Health and Human Services that could enable the Department to more closely monitor and support enforcement, if interpreted in such a manner); see also Skinner, *supra* note 17, at 55-7.

<sup>156</sup> See *supra* notes 145, 152 and accompanying text.

<sup>157</sup> Skinner, *supra* note 17, at s57-8.

<sup>158</sup> *Id.*

<sup>159</sup> *Id.* at 55.

<sup>160</sup> *Id.* at 58.

<sup>161</sup> *Id.* at 54 (“These examples make clear that the politics of medical necessity plays out both on the level of physicians’ inability or unwillingness to recognize LGBT-specific needs as well as health insurance providers’ unwillingness to respect physicians’ medical necessity determinations because they do not jibe with the heteronormative basis of their benefits frameworks”).

generalized benefit classes that are parsed out on specific issues; insurer's similarly have discretion for treating some conditions, excluding others, and limiting treatment options.<sup>162</sup> The most effective, though arduous, means to address this problem would be through legislation and enacting complementary policies that limit exclusions for mental health conditions.<sup>163</sup> At the same time, overarching policy should recognize that mental health may be different from physical health in that particular populations may require different services than other populations, or even from the general population.<sup>164</sup> Taking the debate to the national and state congresses will be a lengthy and time-consuming endeavor, but need not be the only route taken to build a groundswell for reform.

Certain acts by legislatures may help greatly improve access to mental health benefits. For instance, a statutory grant of *de novo* review (reviewing a case for its merits and facts) to courts and an external appeals system for medical necessity claims could allow a valid claimant to seek legal relief on more substantive considerations than on solely procedural grounds.<sup>165</sup> The threshold of arbitrary and capriciousness, wherein the threshold to overcome for insurers is merely to show that a decision occurred through a process and the denial of benefits could be reasonable under a certain light, affords little protection to claimants challenging a determination of fact.<sup>166</sup> A decision may indeed be reasonable when judged procedurally; however, the heart of the conflict is in the substantive right to have equitable access to essential mental health care.

#### **D. Consumer-Driven Health Care**

Reforms need not necessarily originate through regulation and government oversight; market solutions that emphasize the buying power of consumers for shaping the coverage of their health insurance plans are hypothetically vehicles for change.<sup>167</sup> Proponents of this approach argue that consumers choosing health plans that provide the coverage they want could remedy a market failure in providing access to the mental health coverage sought by consumers.<sup>168</sup> For instance, consider the tongue-in-cheek example of the medical necessity of erectile dysfunction medication, which underscores the contention that medical necessity is always objective from the patient's perspective.<sup>169</sup> Regulators, from the national or state levels of government, would be poor replacements for an informed consumer.<sup>170</sup>

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<sup>162</sup> ROSENBAUM, HEALTH STATUS, *supra* note 94, at 16.

<sup>163</sup> *Id.* at 10.

<sup>164</sup> *Id.* at 18.

<sup>165</sup> *Id.*

<sup>166</sup> *Id.* (stating that, whether one's mental health needs were actually medically necessary [bearing in mind that medical necessity is determined by insurers who thereby shape what is and is not considered medically necessary]).

<sup>167</sup> See Michael Cannon, *There Is No Objective Definition of 'Medical Necessity'*, CATO INST. BLOG (Feb. 29, 2012, 10:42 AM), <http://www.cato.org/blog/there-no-objective-definition-medical-necessity>.

<sup>168</sup> *Id.*

<sup>169</sup> *Id.*

<sup>170</sup> *Id.* See also John Goodman, *What Is Consumer-Directed Health Care?*, 25 HEALTH AFF. w540 (2006), <http://content.healthaffairs.org/content/25/6/w540.full.pdf> ("No one is in a better position to

The trouble with the consumer-driven model is not that it lacks merit, but, instead, that it presupposes an informed consumer who both knows what they need in terms of mental health coverage and either has access to plans that can provide those benefits (presumably by classifying access to them as medically necessary) or can effectively negotiate for those benefits.<sup>171</sup> Consumer-driven approaches generally ignore or leave unconsidered a larger public health goal of addressing populations who have physical and mental health needs, some of whom will not have the ability to negotiate for themselves and are thus dependent on the public guarantors of health systems for adequate and necessary coverage.<sup>172</sup> Economically marginalized populations rely on public institutions for ensuring their health equity, so addressing their needs as consumers may prove less efficacious than addressing their rights as human beings in securing essential and quality mental health care.

## PROPOSALS AND CONCLUSION

Access to mental health care pales in comparison to access to physical health care.

In terms of coverage, mental health illnesses and disorders are addressed in a patchwork of federal and state requirements. Multi-dimensional and inconsistent medical necessity requirements currently discriminate against mental health sufferers. Seeking a universal definition for medical necessity that does not preserve some flexibility may not serve marginalized groups, but neither will permitting a multiverse of definitions that all work to exclude the same individuals. Access to mental health care must be neither more restricted nor less restricted than access to physical health care to achieve true parity as the ACA and MHPAEA require. Presuming that both these laws continue in the United States and particularly the ACA (and if not the laws themselves the spirit and purpose of those laws), greater effort is needed on behalf of government to safeguard equal and equitable access to essential mental health care.

Insurers solely define what is medically necessary to access benefits and possess all-but-unlimited power in determining under what terms access is granted.<sup>173</sup> Given that their interests and those of their patients do not always align, the patients' rights and mental health needs can be secondary to the potentially draconian determinations of an insurance enterprise. This raises the real possibility of discrimination against persons or populations who need, and have contracted for, mental health benefits. Many vulnerable groups depend on the state for protection, and the state has insufficiently provided it.

Medical necessity criteria should be disclosed, explained, and understood by policyholders from the onset. Providing consumers with clear criteria for evaluating medical necessity in advance of any claim saves time and resources.<sup>174</sup> Nonbinding and technical guidelines are a start, but every policyholder and consumer should have a complete picture of the criteria used to evaluate claims. Holding insurers accountable

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make these subjective trade-offs than patients themselves").

<sup>171</sup> See Skinner, *supra* note 17, at s58.

<sup>172</sup> *Id.*

<sup>173</sup> Skinner, *supra* note 17, at s50-1.

<sup>174</sup> NAMI, *supra* note 45, at 5, 12; Cohn, *supra* note 44.

to the terms of their agreements will continue to be difficult when purchasers of these policies are not fully made aware and have little means to become suitably edified. At the very least, it would allow consumers to make better choices in both their purchasing and, if challenging a denial, their litigation.

As it stands, the conversation on the inadequacy of access to mental health coverage is restricted in its forums. The courts seldom delve into the content of policy coverage, except for where legislation commands policies to cover particular treatments, conditions, and benefits. The courts should not be the sole forum for this debate since private enforcement of a mental health right can be prohibitively costly and risks adverse judgment.<sup>175</sup> Moreover, the courts are not always the best institution for reform; legislatures and policymakers ought to set overarching guidelines for what benefits must be provided and how those benefits may be enjoyed.

Such guidelines should begin with decoupling medical necessity from physical health, in full recognition that mental health is an independent, though interrelated, component to wellbeing.<sup>176</sup> Legislators should also reconsider the broad deference courts are giving to insurers and require courts, through enabling statutes, to apply higher scrutiny to both the substance of plans and the procedures for review that lead to a denial. Consumers should not be forced to settle for less care merely as a financial convenience to the insurer, particularly when the care sought formed a basis for the consumer's purchasing the policy. Where denials occur, the rationale for denying care should rest on more than a scintilla of evidence that may not even be the best from the perspective of patient care.<sup>177</sup>

Congress should undertake legislation ensuring just and equitable access to mental health treatments and benefits, particularly for marginalized groups who otherwise have few means to effectuate reform themselves. This is no small proposal and national politics may hamstring legislation, but the purpose of Congress should be to serve and support the welfare of all Americans, including those who have mental health needs and especially those who face barriers to addressing their mental health needs. The same effort should be expended in the state legislatures, where those efforts may bear more fruitful outcomes given the states' responsibilities for enforcing parity.<sup>178</sup>

The Department of Labor and Department of Health and Human Services should take on greater oversight responsibility for this at-present discriminatory barrier to access so as to ensure equal protection and uniform application of true mental health parity. The federal departments should exercise their authority to set a uniform federal principle governing medical necessity that shifts the focus of medical necessity to what the patient actually needs. Such action should include improved monitoring of insurer compliance with parity and tougher scrutiny of both substantive policies and the procedure for making medical necessity determinations.

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<sup>175</sup> SAMHSA, *Medical Necessity*, *supra* note 127 and accompanying text.

<sup>176</sup> NAMI, *supra* note 45, at 4-7.

<sup>177</sup> See, e.g., Carlo B. *ex rel.* C.B. v. Blue Cross Blue Shield of Mass., No. 2:08-CV-0059 BSJ, 2010 WL 1257755, at \*3.

<sup>178</sup> Skinner, *supra* note 17, at s54-55, 58.

Mental health is a necessary component to overall health, and access to mental health care is a right created by law for the express purpose of promoting health. Denial of this right by a private entity must not be justified in such blasé terms as industry knows best. Public health is a social commitment that the government makes to the people, who rely on the government to follow through. The United States made this commitment, and must be held accountable.





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