

## **TIMOTHY'S LAW: INTRODUCING NEW YORK TO MENTAL HEALTH PARITY**

### INTRODUCTION

Joe O'Clair's job with the New York State Thruway Authority provided health insurance for his family—his wife Donna and his three sons, John, Christopher, and Timothy. Timothy, unfortunately, was diagnosed with depression, oppositional defiance disorder, and other mental illnesses early in his life. Even more unfortunate was the soon-evident disparity in Joe's health insurance: adequate benefits for physical illnesses, and far less coverage for mental illnesses and treatment. Timothy's mental illnesses required constant treatment and the O'Clairs could only afford limited and sporadic treatment.

On March 16, 2001, Timothy committed suicide. The O'Clairs believed that with more treatment, Timothy's death could have been prevented.

The tragic suicide of Timothy galvanized the O'Clairs and other New Yorkers into resolving the disparate coverage for mental and physical illnesses in employer health plans. Their efforts proved fruitful on December 22, 2006, when Governor George Pataki signed legislation to enact Timothy's Law, which required equal coverage between mental and physical illnesses.

Part I of this Note will discuss the disparity between the coverage provided for mental health illnesses and disabilities in employee benefits plans versus the coverage provided for physical illnesses and disabilities. Introducing the story of Timothy O'Clair, a twelve-year-old boy who suffered from psychological illness and was denied full coverage under his father's employee benefits plan, this section will illustrate the grave results that occur when insurance companies discriminate against mental sickness. This section will also focus on New York State's effort to rectify the disparity in healthcare coverage via its newly passed legislation: "Timothy's Law."

Part II of this Note begins with a survey of scientific studies evaluating mental health parity laws. The results of these studies are then applied to Timothy's Law to predict the likely effects of Timothy's Law

on New York citizens, employers, and insurance companies.

Part III of this Note explores past and present federal mental health parity legislation: the Mental Health Parity Act of 1996, the (many) Mental Health Equitable Treatment Acts, and the Mental Health Parity Act of 2007. These pieces of legislation amount to an insufficient effort to rectify the disparity between mental and physical health care coverage.

In light of the inadequacies of federal legislation, many States have passed their own parity laws. Part IV discusses a sample of these laws as compared to Timothy's Law.

Part V summarizes the preemption clause of the Employee Retirement Income Security Act ("ERISA") and its interplay with parity laws. ERISA preemption of State parity laws, damages for withholding benefits, and damages for medical malpractice are discussed in turn.

The final section of this note, Part VI, considers the progressive nature of State parity laws and their potential influence on federal policymaking. The possible benefits of future federal mental health parity laws are postulated and analyzed with respect to the circular problem of preemption.

## PART I

### *Timothy's Story*

Timothy O'Clair was born May 5th, 1988.<sup>1</sup> By the time Timothy was seven years old, he began to display a severe temper and violent tendencies.<sup>2</sup> The O'Clair family soon recognized that Timothy needed psychological help.<sup>3</sup> For four years they worked with both a psychiatrist in Saratoga County, New York and a psychological group in Albany County, New York, in an effort to get Timothy the mental healthcare he needed.<sup>4</sup> However, his father's health insurance, offered through his employment with the New York State Thruway Authority, provided only meager coverage for mental health visits.<sup>5</sup>

---

1. Timothy's Law, [http://www.timothyslaw.org/timothys\\_story.htm](http://www.timothyslaw.org/timothys_story.htm) (last visited July 11, 2008).

2. *See id.*

3. *Id.*

4. *Id.*

5. *See id.* The insurance coverage, through New York based insurance companies MVP and CDPHP, only permitted a combined total of 20 outpatient visits per year for psychiatrist and

In 1998 Timothy was hospitalized in a psychiatric hospital after refusing to attend school and throwing rags into the furnace at his home.<sup>6</sup> Timothy returned home after his father's insurance company refused to continue to pay for hospitalization.<sup>7</sup> The O'Clairs knew that Timothy's outpatient treatment was beneficial, but it was becoming exponentially too expensive for them to continue to pay without additional help or coverage from his father's health insurance benefit plan.<sup>8</sup> After further violent episodes with Timothy, the O'Clairs reluctantly placed Timothy in foster care.<sup>9</sup> In New York State a child in foster care is automatically eligible for Medicaid, which would pay for the mental health services Mr. O'Clair's insurance carrier denied.<sup>10</sup> Timothy was eventually placed in a psychiatric residency where he remained until January of 2001, when, after showing considerable improvement, he was able to return home.<sup>11</sup> Timothy was home only three short weeks before his behavior again turned violent.<sup>12</sup> On March 16, 2001, Timothy hanged himself in his bedroom closet.<sup>13</sup>

There is a great possibility that, had Joe O'Clair's insurance policy provided equal insurance benefits for both physical and mental illnesses and disabilities, Timothy may have received the healthcare services that his sickness so desperately required.<sup>14</sup> Even after this devastating event, the O'Clairs had to continue to pay for the healthcare treatment bills they incurred throughout Timothy's under-insured illness.<sup>15</sup>

Timothy's story is not an uncommon one. There have been thousands of parents throughout New York State forced to relinquish custody of their children with mental illnesses in order for those children to receive the mental health services they needed.<sup>16</sup> As will be discussed in greater detail in the following sections, New York State and federal legislation fell short of protecting children like Timothy from discriminatory insurance coverage practices. With the passage of Timothy's Law, effective January 1, 2007, New York has tried to

---

psychologist treatment. *Id.*

6. *Id.*

7. *Id.*

8. *See id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

address the lack of parity between insurance coverage provided for mental illnesses and disabilities versus coverage provided for physical illnesses and disabilities.<sup>17</sup> Discussed within are its practical effects on the insurance industry, employee benefits plans, and employees' ability to recover damages under the law in the face of the expansive preemption clause of federally-enacted ERISA.

*What is Timothy's Law?*

Timothy's Law ensures that mental health and chemical dependency coverage is provided by insurers and health maintenance organizations ("HMOs") on terms comparable to other healthcare and medical services.<sup>18</sup> Prior to passing Timothy's Law, health insurance contracts in New York could (a) deny coverage for the diagnosis and treatment of mental, nervous or emotional disorders; (b) place a limit on the number of days or visits permitted; and (c) require different deductibles, coinsurance or co-payments for treatment of mentally-based illnesses.<sup>19</sup>

The intent of Timothy's Law was to end the discriminatory policy of providing benefits or coverage based upon whether a patient's illness or condition is mental or physical.<sup>20</sup> The changes that Timothy's Law implemented in New York State's insurance law included the following provisions: "[e]very insurer delivering a group or school blanket policy" is required to provide coverage for all "mental, nervous or emotional disorders or ailments"<sup>21</sup> and is required to "provide coverage for the diagnosis and treatment of chemical abuse and chemical dependence[;]"<sup>22</sup> insurance companies cannot have separate maximums, independent deductibles or coinsurance amounts, separate out-of-pocket limits, or other limitations on coverage or benefits for mental, nervous or

---

17. SEN. LIBOUS, NEW YORK STATE SENATE, INTRODUCER'S MEMORANDUM IN SUPPORT, S. 8482, 229th Sess. (N.Y. 2006) [hereinafter INTRODUCER'S MEMORANDUM IN SUPPORT]. See generally TIMOTHY'S LAW, ch. 748, N.Y. INS. LAW §§ 3221, 4303 (McKinney 2006 & McKinney Supp. 2008). Pursuant to the codified language of Timothy's law, insurance providers that cover physicians services must provide equal coverage for the "diagnosis and treatment of mental, nervous or emotional disorders or ailments" and "[s]uch coverage shall be provided under the terms and conditions otherwise applicable under the [insurance] contract, including network limitations or variations, exclusions, co-pays, coinsurance, deductibles . . ." § 4303 (h)(1)-(2)(A).

18. See § 4303 (h)(1)-(2)(A).

19. Timothy's Law, *supra* note 1. See also INTRODUCER'S MEMORANDUM IN SUPPORT, *supra* note 17.

20. INTRODUCER'S MEMORANDUM IN SUPPORT, *supra* note 17.

21. §§ 3221(l)(5)(A), 4303(h)(1).

22. *Id.* §§ 3221(l)(6)(A), 4303(k).

emotional disorders or ailments, unless the same limitations are also imposed on physical illnesses covered under the policy or contract;<sup>23</sup> and no insurer may limit benefits or impose cost sharing obligations relating to a specific disease or condition, or for a procedure or treatment unique to a specific disease or condition, in a manner inconsistent with limits or obligations imposed with respect to other diseases or conditions in the health plan.<sup>24</sup>

These changes to New York State insurance law took effect on January 1, 2007, and were to be made available to New Yorkers at the inception of all new contracts and at the anniversary or renewal date of existing contracts.<sup>25</sup>

### *Public Support for Timothy's Law*

New York citizens rallied around Timothy's Law, which resulted in numerous newspaper editorials which urged the legislature and governor to pass it,<sup>26</sup> followed by even more editorials describing the elation felt when Timothy's Law was finally signed into law.<sup>27</sup> The grassroots support for Timothy's Law was further supplemented by New York State regulations requiring publication of its enactment, in order to ensure that employees are aware of their newfound mental health benefits.<sup>28</sup>

---

23. *Id.* §§ 3221(l)(5)(A)(iii), 4303(h)(1).

24. *See id.*

25. Timothy's Law, ch. 748, sec. 1, § 8, 2006 N.Y. Laws at 3723; *see also* INTRODUCER'S MEMORANDUM IN SUPPORT, *supra* note 17.

26. *See generally* Editorial, *Sign Timothy's Law: The Assembly Follows up on Senate Approval of Mental Health Parity Legislation*, ALB. TIMES UNION, Dec. 15, 2006, at A16, available at 2006 WLNR 21836151 (pushing for Governor Pataki to sign Timothy's Law); Editorial, *Sign Timothy's Law: The Mentally Ill Deserve Equal Access to Insurance*, POST STANDARD (Syracuse), Dec. 21, 2006, at A12, available at 2006 WLNR 22351432 (same); Martin Wakesberg, Letter to the Editor, *Timothy's Law is Needed for New York State*, ALB. TIMES UNION, Nov. 20, 2006, at A10, available at 2006 WLNR 20136492 ("It is time to put parochial issues aside in pushing for the passage of this much-needed law, which would truly help all consumers of mental health services."). *But cf.* Group Warns Cost of 'Timothy's Law' Unknown as Bill Passes Assembly, BUS. REV. (Albany), Dec. 14, 2006, available at 2006 WLNR 21578222 (discussing that since the costs of this initiative are still unclear, it might be wise to have a commission to review the mandates of Timothy's Law to ensure that it will not make health insurance be an economical burden).

27. *See generally* Mary Jean Coleman, Letter to the Editor, *Grateful for Enactment of Timothy's Law*, ALB. TIMES UNION, Jan. 2, 2007, at A10, available at 2007 WLNR 56458 ("Thank you, Governor Pataki, for signing Timothy's Law."); Beverly Jean McPeak, Letter to the Editor, *Timothy's Law's Passage is a Gift to Many Suffering*, POST STANDARD (Syracuse), Jan. 1, 2007, at A11, available at 2007 WLNR 35208 (comparing the passage of Timothy's Law to receiving a Christmas gift).

28. N.Y. COMP. CODES R. & REGS. tit. 11, § 52.70(d)(9) (2007). *See generally* Insurance

*Fiscal Impact of Implementing Timothy's Law*

When Timothy's Law was originally proposed, proponents argued that not only was the legislation good for public policy, because it provided relief to individuals in situations similar to that of Timothy O'Clair and his family, but that it was fiscally sound as well.<sup>29</sup> Actuarial analyses demonstrate that insurance coverage for mental illnesses is indeed affordable.<sup>30</sup> In May of 2002, PriceWaterhouseCoopers conducted an actuarial analysis to assess the costs of providing mental health parity.<sup>31</sup> The study determined that the net composite market impact for employer plan healthcare costs would rise about 0.8 percent, or a meager \$1.26 per member per month.<sup>32</sup> In addition to including conservative assumptions that tended to overstate the expected costs of implementing a mental parity plan, the actuarial analysis did not assume any medical offset, disability savings, productivity savings, or any savings from public sector mental health programs, which would have further diminished the actual costs per member per month.<sup>33</sup> After implementation of similar mental health parity laws in other states, those states had negligible changes in plan costs: there was a less than one percent increase in Rhode Island, no increase in New Hampshire, and a 0.2 percent *decrease* in Maryland.<sup>34</sup>

In contrast to the small costs of providing mental health parity, the costs from lost productivity and increased absenteeism, not including unemployment compensation or welfare, was estimated at more than \$44 billion per year.<sup>35</sup> Costs were also incurred as a result of untreated

---

*Companies Ordered to Tell Customers About 'Timothy's Law'*, BUS. REV. (Albany), Feb. 5, 2007, available at 2007 WLNR 2206162 (summarizing an emergency directive ordered by Eric Dinallo, Acting Superintendent of the New York Insurance Department, requiring insurers to alert their customers of the enactment of Timothy's Law and the changes it makes on their insurance agreements); *State Orders Publicity for "Timothy's Law"*, BUS. FIRST (Buffalo), Feb. 5, 2007, available at 2007 WLNR 2206672 (same).

29. See Timothy's Law, *supra* note 1.

30. *Id.* (citing RONALD E. BACHMAN, AN ACTUARIAL ANALYSIS OF COMPREHENSIVE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS FOR THE STATE OF NEW YORK 5 (2002) [hereinafter AN ACTUARIAL ANALYSIS], available at <http://www.timothyslaw.org/actuarialsumm.pdf>).

31. AN ACTUARIAL ANALYSIS, *supra* note 30, at 5.

32. *Id.* at 5.

33. *Id.* at 4.

34. Press Release, Nat'l Alliance on Mental Illness of N.Y. City Metro, Inc., Equal Mental Health Benefits – Good for Families AND Good for Business (May 13, 2003), [hereinafter Equal Mental Health Benefits] available at [www.namincymetro.org/equalbenefits\\_factsheets.html](http://www.namincymetro.org/equalbenefits_factsheets.html) (emphasis added).

35. Timothy's Law, *supra* note 1; Equal Mental Health Benefits, *supra* note 34.

mental illnesses that could cause or “contribute to accidents, job turnover, interpersonal conflict, disability, worker’s compensation, involvement with the criminal justice system, disrupted lives and families, and increased dependency on public resources.”<sup>36</sup>

These issues affected individuals, employers, all levels of government, and society as a whole. Some employers have reported that “costs associated with untreated or poorly managed mental health needs far exceed[ed] direct spending for mental health care.”<sup>37</sup> The data has shown that in 1995 treatment was the source of twenty-eight percent of the annual economic costs of depression, however seventy-two percent of costs were related to absenteeism (twenty-seven percent), lost productivity at work (twenty-eight percent), and mortality costs (seventeen percent).<sup>38</sup> These numbers were staggering when contrasted with the small costs, and in some states actual savings, of mandating mental health parity in insurance law.

### *The Unaffected Segment of the Population*

It is important to consider that not all New Yorkers are covered by the changes in the Insurance Law that Timothy’s Law has implemented. Timothy’s law partially exempts all public employers, self-insured employers, and employers of fifty or fewer individuals.<sup>39</sup> People worried that Timothy’s Law will result in companies losing enormous amounts of money financing the treatment of employees with severe mental illness must be reminded that employers must first *hire* these mentally ill individuals, but individuals with severe mental illnesses have a much higher unemployment rate than the rest of the population.<sup>40</sup> Covering the unemployed, severely mentally ill segment of society

---

36. *Id.*

37. Equal Mental Health Benefits, *supra* note 34.

38. *Id.*

39. Timothy’s Law, ch. 748, sec. 1, § 8, 2006 N.Y. Laws at 3718, 20, 22; *see also* Nat’l Alliance on Mental Illness of N.Y. City Metro, Inc., Timothy’s Law: New York State’s Mental Health Parity Law, <http://www.namincymetro.org/TLC.htm> (last visited July 14, 2008).

40. *See, e.g.*, Center for Mental Health Servs., U.S. Dep’t of Health & Human Servs., *Community Support: About the Program*, <http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/about.asp> (last visited July 13, 2008) (highlighting “an overall national employment rate of 26 percent among a representative sample of persons with severe [mental] disabilities.”); Nat’l Inst. Of Mental Health, *Implementing Evidence Based Practices in New York: Outreach Partnership Program 2005 Annual Meeting*, Apr. 2, 2005, available at <http://www.nimh.nih.gov/outreach/partners/myers2005.cfm> (last visited July 13, 2008) (stating that of the 70% of adults with serious mental illnesses that want to work, only 15% are able to find employment).

would require a far more expansive plan than enacting mental health parity laws, such as adopting a universal health care system.<sup>41</sup>

The aforementioned exemptions of Timothy's Law are also skewed towards providing parity for the middle- and upper-classes over the lower- and working-classes,<sup>42</sup> which may lead to disparate benefits of parity among the races.<sup>43</sup>

## PART II

The impact of mental health parity laws can be measured in a variety of ways. The major segments affected by parity laws are employers, employees (and their families, if any), health maintenance organizations, mental health service providers (ranging from hospitals to psychiatrists), and government departments. The multiple viewpoints of mental health parity laws is made crystal-clear once these segments' points of view are considered, each with financial, quality of life,

---

41. Matt Boucher, Comment, *Turning a Blind (White) Eye in Legislating Mental Health Parity: The Unmet, Overlooked Needs of the Working Poor in Racial and Ethnic Minority Communities*, 19 J. CONTEMP. HEALTH L. POL'Y 465, 492. *But cf.* William P. Gunnar, *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic within the Established Paradigm?*, 15 ANNALS HEALTH L. 151, 154, 179-80 (2006) (taking the position that universal health care, not a fundamental right under the U.S Constitution, is not a feasible possibility in the United States due to the entrenchment of the current health care system).

42. Boucher, *infra* note 43, at 466-67. Exempting self-insured employers and employers of 50 or less individuals places many convenience stores, restaurants, and numerous other low-skill (and low pay) job sites outside the reach of Timothy's Law, allowing those employers to continue to refuse to provide adequate mental health benefits. *See* Nat'l Alliance on Mental Illness of N.Y. City Metro, Inc. *supra*, note 40.

43. *See* Matt Boucher, Comment, *Turning a Blind (White) Eye in Legislating Mental Health Parity: The Unmet, Overlooked Needs of the Working Poor in Racial and Ethnic Minority Communities*, 19 J. CONTEMP. HEALTH L. & POL'Y 465, 468, 486 (2003) (providing an analysis of mental health parity laws from a critical race theorist perspective and evaluating community-based alternatives). A press release for the Mental Health Parity Act of 2007, discussed *infra* Part III, notes that:

[e]vidence indicates a persistent disparity in the mental health status of racial and ethnic minority populations, as compared with the overall mental health status of the U.S. population. Demographic trends indicate that the demand for mental health services tailored to racial and ethnic minorities will increase, but several barriers deter minorities from reaching treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness. . . .

Press Release, U.S. Senate Comm. on Health, Educ., Labor, & Pension, Kennedy, Domenici & Enzi Unveil Long-Awaited Breakthrough on Mental Health Parity: Legislation Will Build on Landmark 1996 Parity Law, at 6 (Feb. 12, 2007) (on file with author), [hereinafter Press Release, Breakthrough on Mental Health Parity] available at [http://help.senate.gov/Maj\\_press/2007\\_02\\_12\\_b.pdf](http://help.senate.gov/Maj_press/2007_02_12_b.pdf).



productivity, and utilization concerns.

*The Prevalence of Mental Illnesses and Disabilities*

According to the Surgeon General, “twenty-eight to thirty percent of adults, and over twenty percent of children and adolescents, have a diagnosable mental or addictive disorder in any given year.”<sup>44</sup> In addition, some employers have discerned that mental disorders are common among their employees, with Westinghouse having reported rates for severe depression to be seventeen percent for women and nine percent for men, and Wells Fargo Bank learning that thirty to thirty-five percent of employees responding to a survey were experiencing symptoms of depression.<sup>45</sup> According to a study conducted by the Robert Wood Johnson Foundation, fifty-five percent of privately insured individuals claimed they did not seek mental health care mainly because of concerns regarding the cost of such health care.<sup>46</sup>

“Of the ten leading causes of disability world-wide, five are psychiatric conditions: unipolar depression, alcohol use, bipolar affective disorder, schizophrenia, and obsessive-compulsive disorder.”<sup>47</sup> The rate of effectiveness for treatment of these conditions ranges from sixty to eighty percent.<sup>48</sup> In addition, it has been estimated that, of a physician’s standard caseload, between fifty and seventy percent of the patients suffer from “medical ailment [that] are significantly related to psychological factors.”<sup>49</sup> This being the case, some believe that the use of medical services, and in turn the cost for such use, would be reduced if mental health care were made available to these patients.<sup>50</sup>

---

44. Equal Mental Health Benefits, *supra* note 34 (citing U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 408-09 (1999) [hereinafter MENTAL HEALTH REPORT], available at <http://www.surgeongeneral.gov/library/mentalhealth/toc.html>).

45. *Id.*

46. *Id.*

47. *Id.* (citing PHYLLIS GABRIEL & MARJO-RIITTA LIIMATAINEN, MENTAL HEALTH IN THE WORKPLACE: INTRODUCTION EXECUTIVE SUMMARIES 1, 17 (2000)).

48. *Id.* (citing NAT’L ADVISORY MENTAL HEALTH COUNCIL, HEALTH CARE REFORM FOR AMERICANS WITH SEVERE MENTAL ILLNESSES: REPORT OF THE NAT’L ADVISORY MENTAL HEALTH COUNCIL (1993); Press Release, Judge David L. Bazelon Center for Mental Health, Policymakers’ Fact Sheet on the Mental Health System (2000), available at [www.bazelon.org/takeaction/legislation/campaign2000factsheet.pdf](http://www.bazelon.org/takeaction/legislation/campaign2000factsheet.pdf)).

49. *Id.*

50. *Id.* (citing Gary R. VandenBos & Patrick H. DeLeon, *The Use of Psychotherapy to Improve Physical Health*, 25 PSYCHOTHERAPY 335, 336 (1988)). See also MKTG. DEP’T PRACTICE DIRECTORATE, AM. PSYCHOLOGICAL ASS’N, MEDICAL COST OFFSET, <http://www.apa.org/practice/offset3.html> (last visited July 14, 2008).

*U.S. Department of Health and Human Services Analysis on Parity  
Laws*

A 1998 report by the Substance Abuse and Mental Health Services Administration (“SAMHSA”) on mental health parity laws<sup>51</sup> concluded that, despite difficulties obtaining data on mental health insurance premiums,<sup>52</sup> “[s]tate [mental health] parity laws have had a small effect on premiums.”<sup>53</sup> While conducting their study, SAMHSA spoke to a variety of organizations affected by parity laws, such as government representatives, employers, and insurers, under a condition of anonymity to ensure confidential and accurate results.<sup>54</sup> Its conclusion was based on four analyses: a comparison of twelve states’ parity legislation,<sup>55</sup> case studies in five states that have had parity legislation for a minimum of one year,<sup>56</sup> reviews of actuarial studies on federal parity legislation,<sup>57</sup> and predicting from an updated actuarial model the costs of full and partial mental health parity.<sup>58</sup>

Some parity laws provide an exemption for self-insured and small business employers.<sup>59</sup> These exemptions have raised concerns that employers will alter insurance practices to take advantage of them,<sup>60</sup> but SAMHSA’s research found that, despite what one may have assumed, “[n]one of the insurers or associations of small employers in [its] study identified [mental health or substance abuse] parity laws as a main

---

51. MERRILE SING ET AL., U.S. DEP’T OF HEALTH & HUMAN SERVS., PUB. NO. MC99-80, THE COSTS AND EFFECTS OF PARITY FOR MENTAL HEALTH AND SUBSTANCE ABUSE INSURANCE BENEFITS (1998), available at <http://mentalhealth.samhsa.gov/publications/allpubs/Mc99-80/Prtyfnix.asp>.

52. *Id.*

For two reasons, many informants could not say exactly if, or by how much, parity raised [mental health or substance abuse] costs or service use. First, data on the subject were sometimes confidential. Second, because [mental health or substance abuse] expenditures are generally a small portion of a health insurer’s total premium, many insurers do not allocate resources to collect these data.

*Id.*

53. *Id.*

54. *Id.*

55. *Id.* The study compared Arkansas, Colorado, Connecticut, Indiana, Maine, Maryland, Minnesota, New Hampshire, North Carolina, Rhode Island, Texas, and Vermont. *Id.*, tbl.1.1.

56. *Id.* SAMHSA conducted case studies in Maryland, Minnesota, New Hampshire, Rhode Island and Texas, all of whom had parity laws in effect for at least one year prior to the studies. *Id.*

57. *Id.*

58. *Id.*

59. See, e.g., Arkansas Mental Health Parity Act, ARK. CODE ANN. § 23-99-504(8) (2006); SING ET AL., *supra* note 51.

60. See SING ET AL., *supra* note 51.

consideration in a decision to self-insure.”<sup>61</sup>

The study also determined that state parity laws had no measured effect on employee productivity or absenteeism.<sup>62</sup> While the researchers conceded that parity laws could arguably improve workplace productivity and efficiency, and that employers would profit from such effects, as well as from less employee absenteeism, “case study informants” either believed parity was ineffectual in this regard or they were unsure of its effects.<sup>63</sup>

SAMHSA’s study differentiates between mental health parity laws covering broad definitions of mental illness, and those covering only serious mental illnesses (“SMI”), or “biologically based” mental illnesses.<sup>64</sup> In order to analyze this study’s relevancy to a prediction of the effects of Timothy’s Law in New York, we must determine to what type of parity law—broad definition or SMI definition—Timothy’s Law is more comparable to. Section 1 of Timothy’s Law, stating the legislative finding and intent, states in part: “[H]ealth insurance policies and health maintenance organization contracts have not provided comparable coverage for adults and children with *biologically based mental illness* or *serious emotional disturbance disorders* affecting children under the same terms and conditions as provided for medical treatment for physical illnesses.”<sup>65</sup> The statute goes on to require insurers issuing group policies that provide for inpatient hospital care to “provide coverage comparable . . . for adults and children with *biologically based mental illness*.”<sup>66</sup> From the legislature’s liberal use of the term “biologically-based mental illness,” and no visible use of another more broad definition of mental illness, it is safe to assume that Timothy’s Law would be classified in SAMHSA’s study as an SMI parity law. SAMHSA’s report does not have scientific results for SMI parity laws isolated from all other parity laws, but they were able to obtain “a very ‘rough’ estimate” of the increase on health care premiums.<sup>67</sup> By using their own tabulated data along with previous studies by Milliman and Robertson, Inc., the researches concluded that SMI parity would increase health premiums by 2.5 percent.<sup>68</sup>

---

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*, tbl.1.1.

65. Timothy’s Law, ch. 748, sec. 1, § 8, 2006 N.Y. Laws at 3717 (emphasis added).

66. *Id.* at 2198 (emphasis added).

67. See SING ET AL., *supra* note 51.

68. *Id.*

*Public Perception of the Impact of Parity Laws*

A study on the public perception of mental health throughout the U.S. divided the 50 states into three separate groups: strong mental health parity states, “medium” mental health parity states, and “weak” or “no” mental health parity states.<sup>69</sup> Although this study was done before the passage of Timothy’s Law, post-Timothy’s Law New York would be best characterized as a “medium” parity state.<sup>70</sup> The study found that states which recently enacted medium mental health parity laws did *not* have a much higher rate of utilization of mental specialty care than those states with weak or no mental health parity laws.<sup>71</sup> Conversely, medium parity legislation was found to increase the use of mental health specialty services among those individuals who already had probable mental health disorders.<sup>72</sup>

While acknowledging the limitations of their study, the researchers explained that their results displayed an inherent weakness in state parity legislation that is not present in comparable federal legislation.<sup>73</sup> They surmised that there are four likely explanations for the statistical weaknesses of state mental health parity laws: (1) self-insured employers, who at one time encompassed an estimated 50% of all insured workers, are exempted from these laws under ERISA;<sup>74</sup> (2) insured individuals may not be know about the improved coverage;<sup>75</sup> (3) managed care organizations may be increasing insurance “carve-outs, which separate[] nominal benefits from actual benefits” to mental health care;<sup>76</sup> and (4) employers are not opposing parity legislation as vigorously in states where it is expected to have severe financial windfalls to “healthcare costs in the states of” the afore-mentioned

---

69. Yuhua Bao & Roland Sturm, *The Effects of State Mental Health Parity Legislation on Perceived Quality of Insurance Coverage, Perceived Access to Care, and Use of Mental Health Specialty Care*, 39 HEALTH SERVS. RES. 1361, 1365 (2004) (noting that for the purpose of the study, weak parity states are categorized with “no parity” states).

70. *See id.* at 1365. Bao and Sturm’s study explains that medium parity laws permit small employer and “if offered” exemptions—both of which are present in Timothy’s Law. *Id. See also* Timothy’s Law, N.Y. INS. LAW § 3221(l)(5)(D)(i) (McKinney 2006).

71. Bao & Sturm, *supra* note 69, at 1374.

72. *Id.* at 1373.

73. *Id.* at 1375 (“The findings suggest that state legislation is unlikely to be an effective substitute for strong federal legislation, but limitations on the study preclude a conclusive answer.”).

74. *Id.* at 1374 (noting that this prevented the state legislation from extending to an adequate amount of people to have a remarkable impact at the “population level”).

75. *Id.* at 1375.

76. *Id.* (citations omitted).

employers.<sup>77</sup>

Three of these explanations are beyond the scope of this Note, but the second explanation, lack of public knowledge regarding improved coverage, is addressed and highly relevant to the subject herein. The arduous journey of Timothy's Law, discussed fully *supra* Part I, details the public support and celebration accompanying its well-publicized passage from a bill into a law. This grassroots support of Timothy's Law galvanized the people of New York in a manner unlike any other state's mental health parity law, and should Timothy's Law show increased utilization of mental health care services at a far higher rate than Bao and Sturm's research results, the remaining states would have a clear idea of how to make their existing parity laws more effective.

The New York Insurance Department issued a regulation ordering the publication of Timothy's Law by February 15, 2007.<sup>78</sup> Specifically, insurers must provide written notice to all policyholders affected by Timothy's Law of the change in insurance law and set up a toll-free customer service telephone number enabling insureds to contact their insurer for Timothy's Law-related inquiries.<sup>79</sup> This regulation was issued with the expressed intention to notify individuals affected by Timothy's Law of their new benefits.<sup>80</sup> A preliminary study by the New York State Department of Insurance surmised that despite this regulation, many New Yorkers may still be unaware of their new mental health benefits.<sup>81</sup> This study was released only six months after the implementation of Timothy's Law, so more time is needed to accurately determine its effects on mental health utilization.<sup>82</sup>

Despite the under-utilization of mental health services that become available with parity laws, research on public opinion has shown

---

77. *Id.* at 1375. An earlier study using a smaller data set found similar results, and the researchers came to the same conclusions as to how state parity laws are "not associated with a significant increase in any of our measures of mental health services utilization." Rosalie Liccardo Pacula & Roland Sturm, *Mental Health Parity Legislation: Much Ado About Nothing?*, 35 HEALTH SERVS. RES. 263, 263 (2000). This study used data from 1997 through 1999, as opposed to the larger timeline of 1997 through 2001 in the Bao & Sturm study. *Id.* at 265-66; Bao & Sturm, *supra* note 69, at 1363.

78. N.Y. COMP. CODES R. & REGS. tit. 11, § 52.70(d)(9) (2007).

79. *Id.* Insurers must also inform those affected that they should expect to receive a "formal contract or certificate amendment," with more comprehensive detail of the benefits. *Id.*

80. See *Insurance Companies Ordered to Tell Customers About 'Timothy's Law'*, *supra* note 28.

81. See Gale Scott, *Mandated Mental Health Coverage Fails to Cause Stir: No Spike in Care or Rate Increases Seen Resulting from Timothy's Law*, CRAIN'S N.Y. BUS., July 23, 2007, available at 2007 WLNR 14463667.

82. See *id.*

widespread public support for parity laws.<sup>83</sup> The public's sympathy for individuals suffering from mental illness may be a cause for this support, as such support is not similarly present for parity laws that would cover substance abuse.<sup>84</sup> This research also showed that the public is wary of the costs associated with parity laws, especially if the parity law required higher taxes or premiums.<sup>85</sup> Public fear of exorbitant costs associated with parity laws is unfounded, as the studies previously discussed have concluded that while there could be *negligible* increased costs for employers, employers may also *save* money as a result of parity laws.<sup>86</sup>

*Mandating Treatment of Depressed Employees: A Potential Financial Windfall for Employers*

Depression is a covered mental illness under Timothy's Law.<sup>87</sup> Depressed employees are more expensive than non-depressed employees, forcing employers to take on anywhere from 70% to 147% higher medical costs.<sup>88</sup>

A 1998 study published by the *Journal of Occupational and Environmental Medicine* found increasing evidence that the effective treatment of depression results in productivity gains that potentially offset the cost of such treatment,<sup>89</sup> thereby making parity laws covering depression a form of cost-saving legislation for employers. Employers,

---

83. See Kristina W. Hanson, *Public Opinion and the Mental Health Parity Debate: Lessons from the Survey Literature*, 49 PSYCHIATRIC SERVS. 1059, 1059 (1998), available at <http://www.psychservices.psychiatryonline.org/cgi/content/full/49/8/1059/>.

84. *Id.* at 1063-64.

85. *Id.* at 1065 (demonstrating that "support for a guaranteed mental health benefit dropped from 69 percent of respondents to 34 percent when the survey questions indicated that higher taxes or premiums would be involved."). *Id.* at 1062-63 (footnote omitted).

86. See *id.* at 1065.

87. Timothy's Law, N.Y. INS. LAW § 3221(5)(B)(ii) (McKinney 2006).

88. Ron Z. Goetzel et al., *The Business Case for Quality Mental Health Services: Why Employers Should Care About the Mental Health and Well-Being of Their Employees*, 44 J. OCCUPATIONAL & ENVTL. MED. 320, 321 (2002) [hereinafter *The Business Case for Quality Mental Health Services*]. The study concluded that depression was the most expensive medical cost, at an increase of 70%, swelling to 147% when combined with high stress. *Id.*

89. *Id.* at 321, 328 (citing Ron Z. Goetzel et al., *The Relationship Between Modifiable Health Risks and Health Care Expenditures: An Analysis of the Multi-Employer HERO Health Risk and Cost Database*, 40 J. OCCUPATIONAL & ENVTL. MED. 843, 843 (1998) [hereinafter *HERO*]). This study polled 46,000 employees to analyze the increase in medical costs caused by ten separate health risk factors. The ten risk factors were "smoking, sedentary lifestyle, high cholesterol, hypertension, poor diet, being overweight, excessive alcohol consumption, high blood glucose, high stress, and depression." *The Business Case for Quality Mental Health Service*, *supra* note 88, at 321.

as they learn that depression influences worker productivity, which in turn affects company performance and competitiveness, are becoming more concerned with how to alleviate this problem.<sup>90</sup> The effects of depression on worker productivity have increased in the last few decades, due to the shift from physical-based labor to knowledge and analytical-based labor.<sup>91</sup> Researchers have found that depressed workers suffered between 1.5 and 2.3 more short-term disability days per thirty-day span than non-depressed workers,<sup>92</sup> and that when they *do* attend work, they lose approximately twenty percent of their productivity due to depression-caused symptoms.<sup>93</sup> Treatment for depression is constantly growing more effective, and parity legislation gives these depressed employees the ability to receive proper care, in turn increasing their workplace productivity and reducing their absenteeism. New York employers falling under the umbrella of Timothy's Law may begin to reap these benefits as well: increased productivity, higher employee morale, and lower employee absenteeism.

### PART III

#### *Federal Mental Health Parity Laws*

Federal mental health parity laws are not as expansive as Timothy's Law. This section discusses the Mental Health Parity Act of 1996,<sup>94</sup> the most recent federal statute mandating some form of mental health parity, the multi-year battle of the Mental Health Equitable Treatment Act,<sup>95</sup> and the potentially forthcoming Mental Health Parity Act of 2007. The shortcomings of these laws have led to States passing their own mental health parity laws, discussed in-depth in Part IV of this Note.

---

90. *The Business Case for Quality Mental Health Service*, *supra* note 88, at 321, 327-28.

91. *Id.* at 322.

92. *Id.* at 324 (citing Ronald C. Kessler et al., *Depression in the Workplace: Effects on Short-Term Disability*, 18 HEALTH AFF. 163 (1999)).

93. *Id.* (footnote omitted).

94. Mental Health Parity Act of 1996 § 712, 29 U.S.C. § 1185a (2006).

95. See Mental Health Equitable Treatment Act of 1999, S. 796, 106th Cong. (1999); Mental Health Equitable Treatment Act of 2001, S. 543, 107th Cong. (2001); Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003, S. 486, 108th Cong. (2003); Mental Health Parity Act of 2007, S. 558, 110th Cong. (2007), available at <http://thomas.loc.gov/cgi-bin/query/z?c110:S.558>.

*Federal Parity: The Mental Health Parity Act of 1996*

The Mental Health Parity Act of 1996 (“MHPA I”)<sup>96</sup> amends portions of the Employee Retirement Income Security Act (“ERISA”)<sup>97</sup> by requiring parity in very limited circumstances.<sup>98</sup> The MHPA I specifies that if a group health plan *chooses* to provide mental health benefits,<sup>99</sup> the plan may only place annual and aggregate lifetime limits if such limits are applied to substantially all other medical and surgical benefits.<sup>100</sup> There is no language in the MHPA I requiring a group insurer to provide coverage for mental illnesses if such coverage is entirely absent from their benefits package.<sup>101</sup>

The MHPA I therefore lacks the necessary teeth to force insurance providers to cover mental illnesses, and a hypothetical scenario seems to sweep this impotence under the rug. Code of Federal Regulations § 146.136, promulgated under the MHPA I, contains an example of the MHPA I in practice: if prior to the effective date of the MHPA I a group health plan did not have an annual limit on medical/surgical benefits but had a \$10,000 limit on mental health benefits, the regulation lists three methods of MHPA I compliance for the plan sponsor.<sup>102</sup> They can: (1) remove the limit from mental health benefits; (2) replace the \$10,000 limit with a \$500,000 limit on all benefits (“including medical/surgical

---

96. The Mental Health Parity Act of 2007 will be referred to as “MHPA II” in this Note and is discussed in detail *infra*.

97. Employee Retirement Income Security Act of 1974 § 2, 29 U.S.C. § 1001 (2000).

98. 45 C.F.R. § 146.136(b) (2007).

99. 29 U.S.C.A. § 1185a(b)(1) (2007) (“Nothing in this section shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits . . .”). This subsection makes the name “Mental Health Parity Act” a misnomer. “Parity” is defined as “the state or condition of being the same in power, value, rank, etc.; equality.” WEBSTER’S NEW WORLD COLLEGE DICTIONARY 1047 (4th ed. 2001). The dictionary definition of “parity” is not achieved by the Mental Health Parity Act of 1996, because it leaves the decision regarding mental benefits solely to the discretion of the insurance company/employer. The Mental Health Parity Act would be more accurately titled “The Mental Health Mandated Offering Act of 1996,” as mandatory benefit laws do not always require mental illness coverage.

100. § 1185a(a)(1)(A).

101. See Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 17 (2000) (citing 29 U.S.C. § 1185a(b)(1), *Oversight of Tax Law Related to Health Insurance: Hearing Before the Subcomm. On Oversight of the H. Comm. on Ways & Means*, 105th Cong. 54 (1998) (statement of James A. Klein, President Ass’n of Private Pension & Welfare Plans)); Sara Noel, Comment, *Parity in Mental Health Coverage: The Goal of Equal Access to Mental Health Treatment Under the Mental Health Parity Act of 1996 and the Mental Health Equitable Treatment Act of 2001*, 26 HAMLINE L. REV. 377, 388 (2003) (citing 42 U.S.C. § 300gg-5(b)(1)(2000)).

102. 45 C.F.R. § 146.136(b)(4)(i) (2007).



and mental health benefits”); or (3) apply a \$250,000 limit to mental health benefits and a \$250,000 limit to medical/surgical benefits.<sup>103</sup> This regulation proceeds to list multiple examples of the various methods of compliance with the MHPA I,<sup>104</sup> but in each instance, fails to suggest that a health provider could avoid the scope of the MHPA I entirely by removing all mental health coverage from their health plans. The “Applicability” section of the regulation addresses this confusion, explaining that the MHPA I applies only to group health plans and health insurance insurers offering mental health benefits.<sup>105</sup>

Instead of complying with the MHPA I by enacting policies to increase coverage for mental illnesses, employers found loopholes in the statute and exploited them in order to achieve compliance. A 2002 report by the American Psychological Association declared that eighty-seven percent of employers in compliance with the law decreased components of mental health coverage not controlled by the MHPA I, rendering the effects of the law moot.<sup>106</sup> The shortcomings of the MHPA I were emphasized by Senator Domenici, its original sponsor and a longtime proponent of further federal parity legislation.<sup>107</sup>

#### *The Many Mental Health Equitable Treatment Acts*

The Mental Health Equitable Treatment Act has been introduced in Congress numerous times and failed to become a law in each instance.<sup>108</sup> Addressing the shortcomings of the Mental Health Parity Act of 1996, the Mental Health Equitable Treatment Act of 1999 (“MHETA I”) intended “[t]o provide for full parity with respect to health insurance coverage for certain severe biologically based mental illnesses and to prohibit limits on the number of mental-illness-related hospital days and outpatient visits that are covered for all mental illnesses.”<sup>109</sup> This act

---

103. *Id.* §§ 146.136(b)(i)(A)-(C).

104. *Id.*

105. *Id.* at § 146.136(d)(1)-(2) (emphasizing that the criteria of the MHPA I only pertain to plans and issuers providing both medical/surgical and mental health benefits).

106. Am. Psychol. Ass’n, *Parity Loopholes Should Be Closed for all Mental Illnesses* (Feb. 2002), available at [http://www.apa.org/practice/parity2002\\_2.html](http://www.apa.org/practice/parity2002_2.html).

107. 147 CONG. REC. S2390-01, S2393 (daily ed. Mar. 15, 2001) (statement of Sen. Domenici) (emphasizing the exploited loopholes of the MHPA and the irony of covering treatments for heart conditions with moderate success rates yet failing to cover mental illness treatments with noticeably higher success rates).

108. See Library of Cong., [www.thomas.gov/cgi-bin/bdquery/z?d107:SN00543:@@D&summ1&](http://www.thomas.gov/cgi-bin/bdquery/z?d107:SN00543:@@D&summ1&) (last visited July 17, 2008) (chart summarizing history of MHETA).

109. Mental Health Equitable Treatment Act of 1999, S. 796, 106th Cong. pmb. (1999).

failed to become a law,<sup>110</sup> as did the subsequent and virtually identical Mental Health Equitable Treatment Act of 2001 (“MHETA II”)<sup>111</sup> and Mental Health Equitable Treatment Act of 2002 (“MHETA III”).<sup>112</sup>

The Sisyphean<sup>113</sup> journey of the Mental Health Equitable Treatment Act continued in 2003, when it was introduced for a final time.<sup>114</sup> A well-articulated argument in support of the MHETA III is found in Representative Patrick J. Kennedy’s article, “*Why We Must End Insurance Discrimination Against Mental Health Care.*”<sup>115</sup> Kennedy’s pleas fell on deaf ears, as the MHETA III, like its predecessors, failed to become a law. The next attempt by the federal legislature to close the gap between mental and physical illness coverage would not come until the Mental Health Parity Act of 2007, described below.

### *The Mental Health Parity Act of 2007*

On February 12, 2007, Senators Kennedy, Domenici, & Enzi introduced to Congress the Mental Health Parity Act of 2007 (“MHPA II”).<sup>116</sup> The MHPA II seeks to close the loopholes left open by the MHPA I by requiring parity for a detailed list of conditions, such as deductibles, co-payments, annual and lifetime limits, number of hospital days and visits, etc., as opposed to the meager annual and lifetime limits

---

110. See Library of Cong., *supra* note 108.

111. Mental Health Equitable Treatment Act of 2001, S. 543, 107th Cong. (2001).

112. Mental Health Equitable Treatment Act of 2002, H.R. 4066, 107th Cong. (2002).

113. Sisyphus, a character from Greek mythology, was sentenced by the Gods to remain in the underworld rolling a large boulder to the top of a hill, only to have the boulder slip from his grasp and roll back to the base before reaching the top. 10 ENCYCLOPEDIA BRITANNICA INC., THE NEW ENCYCLOPEDIA BRITANNICA 848 (15th ed. 1994) (1768).

114. See Library of Cong., [www.thomas.gov/cgi-bin/bdquery/z?d108:SN00486:@@&d&summ2=m&](http://www.thomas.gov/cgi-bin/bdquery/z?d108:SN00486:@@&d&summ2=m&) (last visited July 17, 2008).

115. Patrick J. Kennedy, Policy Essay, *Why We Must End Insurance Discrimination Against Mental Health Care*, 41 HARV. J. ON LEGIS. 363, 366, 368-74 (2004) (referring to MEHTA III as the “Wellstone Act,” named after Senator Paul Wellstone from Minnesota, an advocate of mental health parity).

116. Mental Health Parity Act of 2007, S. 558, 110th Cong. (2007), available at <http://thomas.loc.gov/cgi-bin/query/z?c110:S.558>. See also 153 CONG. REC. S1850-01, S1864-65 (daily ed. Feb. 12, 2007) (statements of Sen. Domenici & Sen. Kennedy) (explaining the exploited loopholes of the MHPA I and the intended effects of the MHPA II); Press Release, Kennedy, Domenici, & Enzi Unveil Long-Awaited Breakthrough on Mental Health Parity: Legislation Will Build on Landmark 1996 Parity Law (Feb. 12, 2007), available at [http://help.senate.gov/Maj\\_press/2007\\_02\\_12\\_b.pdf](http://help.senate.gov/Maj_press/2007_02_12_b.pdf). See generally Nat’l Alliance on Mental Illness, Details and Background on the Mental Health Parity Act of 2007 (Feb. 13, 2007), available at <http://www.nami.org/Template.cfm?Section=February10&Template=/ContentManagement/ContentDisplay.cfm&ContentID=43285> (discussing the evolution of the Mental Health Parity Act of 2007).

of the MHPA I.<sup>117</sup> Similar to Timothy's Law, the MHPA II contains an exemption for employers with less than fifty employees.<sup>118</sup> The MHPA II also contains a "Cost Exemption," which exempts health insurance providers who show projected total cost of coverage increases of at least two percent during the first year or more than one percent each subsequent year.<sup>119</sup> The employers who would qualify for this cost exemption would be a clear-cut minority, as the Congressional Budget Office estimates have shown less than a one percent cost increase to employers.<sup>120</sup> The MHPA II will affect the health plans of an estimated 113 million Americans, and would preempt any state laws limiting the number of mental illness-related treatment days or visits.<sup>121</sup> All providers would also be required to inform all insureds of alterations in their coverage relating to the MHPA II.<sup>122</sup> The MHPA II passed in the Senate on September 18, 2007, and is currently in the House Subcommittee on Health, Employment, Labor, and Pensions.<sup>123</sup> With the support of the public and major insurance carriers<sup>124</sup> it may one day become a law and bring American citizens one step closer to full mental health parity.

#### PART IV

##### *State Mental Health Parity Laws*

Before Timothy's Law was passed, forty-six states had laws that

---

117. Compare Press Release, Breakthrough on Mental Health Parity, *supra* note 44, at 2, with Mental Health Parity Act of 1996 § 712, 29 U.S.C. § 1185a(a)(1)-(2) (2006).

118. Compare Press Release, Breakthrough on Mental Health Parity, *supra* note 44, at 3, with N.Y. INS. LAW § 3221(5)(D)(i).

119. Press Release, Breakthrough on Mental Health Parity, *supra* note 44, at 3.

120. *See id.* at 4.

121. *Id.* at 3-4.

122. *Id.* at 5.

123. See Library of Cong., <http://thomas.loc.gov/cgi-bin/dbquery/z?d110:SN00558:@@R> (last visited July 17, 2008).

124. See Press Release, Aetna, Aetna Statement in Support Of Mental Health Parity Act of 2007 (Feb. 14, 2007), available at <http://www.aetna.com/news/2007/0214.htm>

Aetna supports this legislation and will work with Congress to see that it is enacted without modifications that undermine the compromise forged by Senators Kennedy, Domenici and Enzi . . . Aetna is supportive of the principles and approach embodied in this legislation. If passed, we believe our members will benefit by being better able to achieve their optimal health through more integrated health and behavioral programs, benefits and services.

*Id.* (quoting Mary Fox, head of Medical Related Products).

mandated or regulated mental health benefits.<sup>125</sup> These laws can be generally divided into three categories: (1) mental health parity laws, (2) minimum mandated health benefit laws, and (3) mandated health offering laws.<sup>126</sup> As Timothy's Law falls under the category of "mental health parity law,"<sup>127</sup> the following is a sample of other states' mental health parity laws and how they compare to Timothy's Law. Most of these laws define "mental illness" according to the definition found in the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"), as published by the American Psychiatric Association.<sup>128</sup>

The Arkansas Mental Health Parity Act<sup>129</sup> was created to make "insurance coverage for mental illnesses and . . . mental health treatment . . . available and at parity with that for other medical illnesses."<sup>130</sup> The

---

125. See Nat'l Conf. of State Legs. *Health Care: State Laws Mandating or Regulating Mental Health Benefits* (July 2007), <http://www.ncsl.org/programs/health/mentalben.htm> [hereinafter Nat'l Conf. of State Legs.]; See, e.g., ARIZ. REV. STAT. ANN. § 20-2322 (2006); Arkansas Mental Health Parity Act, ARK. CODE ANN. §§ 23-99-501 to 502 (2006); CAL. INS. CODE § 10144.5 (West 2005); COLO. REV. STAT. ANN. § 10-16-104(5) (West 2006); CONN. GEN. STAT. ANN. §§ 38a-488a(a), 38a-514(a) (West 2007); DEL. CODE ANN. tit. 18, § 3343(b) (2006); FLA. STAT. ANN. § 627.668 (West 2005); GA. CODE ANN. § 33-24-28.1(b), 33-24-29(c) (2005); HAW. REV. STAT. § 431M-5(c) (2005); 215 ILL. COMP. STAT. ANN. 5/370c (West 2000); IND. CODE ANN. § 27-13-7-14.7 (West 2006). Other states with laws regulating mental health include Alabama, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. See Nat'l Conf. of State Legs., *supra*.

126. Nat'l Conf. of State Legs., *supra* note 125. The most progressive mental health parity laws require insurers to provide the same benefits for mental illnesses as are provided for all other physical illnesses. See John V. Jacobi, *Parity and Difference: The Value of Parity Legislation for the Seriously Mentally Ill*, 29 AM. J.L. & MED. 185, 190 (2003). Minimum mandated health benefit laws allow for variations between the benefits provided mental and physical illnesses, but establish a baseline level of benefits for mental illnesses that an insurer must provide for. *Id.* Mandated offering laws either require that the insurer provide an option of mental health coverage (at a higher premium, if they so desire), or require that if the insurer chooses to offer coverage for mental health benefits, the coverage must be equal to that for physical illnesses. *Id.* at 191; see also Nat'l Conf. of State Legs., *supra* note 125.

127. Timothy's Law, ch. 748, sec. 1, § 8, 2006 N.Y. Laws at 3717. ("[I]t is the intent of this legislation . . . to ensure that mental health coverage is provided by insurers and health maintenance organizations, and is provided *on terms comparable to other health care and medical services.*" (emphasis added)). As explained, *supra* note 126, laws requiring equal/comparable benefits for physical and mental illnesses are classified as mental health parity laws.

128. Compare N.H. REV. STAT. ANN. § 417-E:1(III) (2006), with 215 ILL. COMP. STAT. ANN. 5/370c(b)(2).

129. Arkansas Mental Health Parity Act, ARK. CODE ANN. § 23-99-501 (LexisNexis 2004).

130. *Id.* See also Teri Chastain Wadley, *Survey of Legislation 1997 Arkansas General Assembly – Insurance Law*, 20 U. ARK. LITTLE ROCK L. REV. 481, 483 (1998) (providing a brief overview of Arkansas Mental Health Parity Act).

act explicitly states that mental illnesses and developmental disorders shall be treated under the same terms and conditions as other medical illness, with no discrepancy between coverage duration and financing.<sup>131</sup> This act and Timothy's Law both provide exemptions for small employers with 50 or fewer employees.<sup>132</sup>

New Hampshire's mental health parity law requires all group health insurers to provide benefits for certain mental illnesses "that are no less extensive than coverage for other physical illnesses."<sup>133</sup> The statute includes a list of covered mental illnesses that are defined with reference to the DSM,<sup>134</sup> but the legislature chose to fashion their own definition of "mental illness" as used in the statute.<sup>135</sup> The seeming confusion created by a legislature fashioning their own definition for mental illness, followed by stating that specific mental illnesses are to use the definitions of the DSM, is not apparent in other states' parity laws.<sup>136</sup> Illinois' mental health parity statute calls for mental illness to be treated under the same terms and conditions as other illnesses and diseases, but states that "the insured may be required to pay up to [fifty percent] of expenses incurred . . . and the annual benefit limit may be limited" in relation to mental illness treatment.<sup>137</sup> Illinois' statute therefore places a substantial limitation on mental health parity that can be exercised at the behest of insurance providers. Illinois' statute also includes a short list of what psychiatric illnesses are covered,<sup>138</sup> something also found in Timothy's Law,<sup>139</sup> New Hampshire's parity law,<sup>140</sup> California's parity law,<sup>141</sup> South Dakota's parity law,<sup>142</sup> and others.

---

131. § 23-99-506(b).

132. Compare N.Y. INS. LAW § 3221(l)(5)(D)(i) (McKinney 2008), with §§ 23-99-503(8), 23-99-503(8) (providing exemptions for employers of fifty or less individuals).

133. N.H. REV. STAT. ANN. § 417-E:1(I) (2006).

134. § 417-E:1(III)(a)-(i).

135. § 417-E:1(I). "[A] clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." *Id.*

136. Other states' mental health parity laws choose to exclusively use DSM definitions. 215 ILL. COMP. STAT. ANN. § 5/370c(b)(2) (West Supp. 2007), ARK. CODE ANN. § 23-99-503(6) (2004). Others make no mention of DSM definitions whatsoever. VT. STAT. ANN. tit. 8, § 4089b(a)(2) (2006).

137. 215 ILL. COMP. STAT. ANN. §§ 5/370c(a)(2)(i)-(ii), (b)(1).

138. § 5/370c(b)(2)(A)-(J).

139. Timothy's Law, S. 8482 § 2(B), 2006 Sen., 229th Sess. (N.Y. 2006); Assemb. 2912-A, 2006 229th Sess. (N.Y. 2006) § 3(B)(ii).

140. N.H. REV. STAT. ANN. § 417-E:1(III)(a)-(i) (2006).

141. CAL. INS. CODE § 10144.5(d)(1-9) (West 2006).

142. S.D. CODIFIED LAWS § 58-17-98 (2006).

In 1998, South Dakota enacted one of the most concise mental health parity laws in the United States.<sup>143</sup> The statute in its entirety states:

Every policy of health insurance that is delivered, issued for delivery, or renewed in this state, except for policies that provide coverage for specified disease or other limited benefit coverage, shall provide, in writing, coverage for the treatment and diagnosis of biologically-based mental illnesses with the same dollar limits, deductibles, coinsurance factors, and restrictions as for other covered illnesses. The term, biologically-based mental illness, means schizophrenia and other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder.<sup>144</sup>

South Dakota's law, like Timothy's Law, makes no reference whatsoever to the DSM, instead it relies on a short list of general mental conditions that fall under the statutory definition of "mental illness."<sup>145</sup>

Vermont's mental health parity law<sup>146</sup> is one of the most wide-reaching in the nation,<sup>147</sup> requiring full parity for the treatment of all mental illnesses listed in the DSM,<sup>148</sup> in addition to alcohol and substance abuse treatment.<sup>149</sup> The statute also provides that mental health conditions shall not be subject to different rates or terms that would prove financially burdensome to the insured; a stark difference from the limitations present in Illinois' parity law.<sup>150</sup>

Nebraska's mental health parity law is very limited in scope when compared to other states, as it allows insurance providers to give no coverage whatsoever for mental illnesses, as long as they "provide clear and prominent notice of such noncoverage in the plan."<sup>151</sup> Therefore, *should* a Nebraska insurance provider *choose* to provide coverage for mental illness treatment, a decision made entirely on their own accord,

---

143. § 58-17-98.

144. § 58-17-98.

145. *Compare*, § 58-17-98, with N.Y. INS. LAW § 3221(l)(5)(B)(ii) (McKinney 2008), (providing a short and generalized list of "mental illnesses").

146. VT. STAT. ANN. tit. 8, § 4089b (2006), *amended by* 2006 Vt. Acts & Resolves 129 H. 404.

147. 29 AM. J.L. & MED. 185, 191 (2003).

148. § 4089b(a)(2).

149. *See* § 4089b(e)(2)(A)-(B).

150. *Compare* § 4089b(b)(1) (stating that all rates/terms must be equal), with 215 ILL. COMP. STAT. ANN. 5/370c(a)(1)-(b)(2)(ii) (West Supp. 2007) (allowing insurers to create varying rates). The Vermont statute explicitly states that all rates/terms must be equal, while the Illinois statute allows insurers to create varying rates.

151. NEB. REV. STAT. ANN. §§ 44-791 to 795 (Lexis Nexis 2006); § 44-793(1)(b).

the rates, terms, and conditions of such coverage must not exceed those of physical health treatment.<sup>152</sup>

### *California's Mental Health Parity Law as a Case Study*

California's mental health parity law<sup>153</sup> mandated parity for all plans "issued, amended, or renewed on or after July 1, 2001."<sup>154</sup> The similarities between California's parity law and Timothy's Law are explained earlier in this Note.<sup>155</sup> A 2002 case study of two large employer groups in California showed differing financial results, possibly caused by different types of health care plans.<sup>156</sup> Employer A's workforce, all under a single managed care health plan, had relatively high costs and high service use, and comparing costs before and after parity showed a 1.9 percent post-parity decline in total spending.<sup>157</sup> Employer B's workforce was covered by a variety of plans with different levels of service coverage, and their total health care spending sustained an increase of less than one percent.<sup>158</sup> This study is further evidence that the fears of Timothy's law unduly burdening employers<sup>159</sup> are groundless, as there is no statistical evidence to show heavy cost increases.

## PART V

### *The Employment Retirement Income Security Act*

The Employment Retirement Income Security Act was enacted in 1974 by Congress as a basis for federally supervising employee benefit plans, and was justified by the need for protection of interstate

---

152. See § 44-793(1)(a)(i).

153. CAL. INS. CODE § 10144.5(a) (West 2005 & West Supp. 2008).

154. *Id.*

155. *Infra* Part V. *Supra* Part IV.

156. Robert B. Branstrom & Roland Sturm, *Economic Ground Rounds: An Early Case Study of the Effects of California's Mental Health Parity Legislation*, 53:10 PSYCHIATRIC SERVS. 1215, 1215-16 (2002).

157. *Id.* at 1216.

158. *Id.*

159. See generally *Group Warns Cost of 'Timothy's Law' Unknown as Bill Passes Assembly*, BUS. REVIEW (Albany), Dec. 14, 2006, available at 2006 WLNR 21578222 (proclaiming that because lawmakers are unable to give an exact forecast of the financial implications of Timothy's Law, not only will Timothy's Law *cost* employers (as opposed to produce savings), but these costs may be too much for employers to bear).

commerce and other federal interests.<sup>160</sup> The primary purpose of ERISA was to remedy defects in the private retirement system which threatened individual pension and benefits rights.<sup>161</sup> Congress wanted to ensure that: “1) employees [were] not deprived of anticipated retirement benefits by termination of pension plans before sufficient funds [were] accumulated”;<sup>162</sup> 2) employers were encouraged to establish pension plans by providing favorable tax treatment for plans which complied with ERISA requirements;<sup>163</sup> and “3) discrimination in retirement laws against people who were self-employed was eliminated.”<sup>164</sup>

The employee benefit plans regulated by ERISA are described within Section 1003(a).<sup>165</sup> These include any “benefit plan that is established or maintained by any employer engaged in commerce or in any industry or activity affecting commerce,”<sup>166</sup> or “any employee organization(s) representing employees engaged in commerce or in any industry or activity affecting commerce.”<sup>167</sup> The employee benefit plans that are exempted from ERISA regulation are enumerated in Section 1003(b) and include:

- (1) [g]overnmental plans, (2) [c]hurch plans, (3) [any] plan that is maintained solely for the purpose of complying with workmen’s compensation or disability insurance laws, (4) [any] plan that is maintained outside of the United States primarily for the benefit of persons who are nonresident aliens, and (5) [any] plan which is an excess benefit plan and is unfunded.<sup>168</sup>

To achieve uniform ERISA application to all employee benefit plans, Congress included a preemption clause so that individually passed state laws could not circumvent the legislation.<sup>169</sup> That preemption clause, Section 1144(a), states that “the provisions of [ERISA] shall

---

160. John F. Wagner, Annotation, *Construction and Application of Preemption Exemption, Under Employee Retirement Income Security Act* (29 U.S.C.S. § 1001 et seq.), *For State Laws Regulating Insurance, Banking, or Securities* (29 U.S.C.S. § 1144(b)(2)), 87 A.L.R. FED. 409 (1988).

161. 70 C.J.S. *Pensions* § 13 (2006).

162. *Pension Benefits Guar. Corp. v. R.A. Gray & Co.*, 467 U.S. 717, 720 (1984) (citing *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361-62, 374-75 (1980)).

163. *Gillis v. Hoechst Celanese Corp.*, 4 F.3d 1137, 1145 n.6 (3d Cir. 1993).

164. *See Commercial Mortgage Ins. Inc. v. Citizens Nat’l Bank of Dallas*, 526 F. Supp. 510 (1981).

165. *Employee Retirement Income Security Act*, 29 U.S.C. § 1003(a) (2001).

166. 29 U.S.C. § 1003(a)(1) (2001 & Supp. 2007).

167. § 1003(a)(2).

168. § 1003(b)(1)-(5).

169. *See* 29 U.S.C.A. § 1144(a) (West 1998).



supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”<sup>170</sup> However, to avoid infringing upon states’ rights to regulate specific areas of interest, Congress included the caveat in § 1144(b) that “nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.”<sup>171</sup> This caveat has been referred to as the “savings clause” and it limits the broad application of state-law preemption by ERISA.<sup>172</sup> When dealing with an employee benefits plan which is a multiple employer welfare arrangement, any law of any state which regulates insurance may survive preemption under the savings clause to the extent that the law provides: 1) standards requiring the maintenance of specified levels of reserves and specified levels of contributions; and 2) provisions to enforce such standards.<sup>173</sup> While the savings clause has helped state laws survive preemption, it has been a source of judicial confusion, interpretation, and reinterpretation by the Supreme Court.<sup>174</sup>

#### *ERISA Preemption of State Parity Laws*

In *Kentucky Ass’n of Health Plans, Inc. v. Miller*<sup>175</sup> (hereinafter “*Miller*”) the U.S. Supreme Court simplified and refined the test for determining whether a state law “regulates insurance” and is saved from preemption under ERISA’s savings clause.<sup>176</sup>

As part of the Kentucky Health Care Reform Act, Kentucky enacted two “Any Willing Provider” (“AWP”) statutes.<sup>177</sup> The first

---

170. 29 U.S.C. § 1144(a) (2000).

171. § 1144(b)(2)(A).

172. *Id.*; see also *Ky. Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 333 (2003) (referring to § 1144(b)(2)(A) as the savings clause).

173. § 1144(b)(6)(A)(i)(I)-(II).

174. See *Miller*, 538 U.S. 329 at 340. Justice Scalia has acknowledged that an analysis of Supreme Court holdings regarding the savings clause may “raise more questions than they answer and provide . . . for divergent outcomes.” *Id.* Justice Blackmun went one step further, criticizing the statute itself: “[t]he two preemption sections, while clear enough on their faces, perhaps are not a model of legislative drafting.” *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985), *overruled by Miller*, 538 U.S. at 340.

175. *Miller*, 538 U.S. 329.

176. § 1144(b)(2)(A); see also Matthew G. Vansuch, Note, *Not Just Old Wine in New Bottles: Kentucky Ass’n of Health Plans, Inc. v. Miller Bottles a New Test for State Regulation of Insurance*, 38 AKRON L. REV. 253, 256 & 257 (2005) (emphasizing *Miller*’s break from precedent and the creation of a new judicial test for ERISA’s savings clause).

177. See *Ky. Health Care Reform Act*, ch. 187, sec. 2, 1996 Ky. Acts (codified as amended at KY. REV. STAT. ANN. § 304.17A-270 (LexisNexis 2005), KY. REV. STAT. ANN. 304.17A-171(2) (LexisNexis 2005)); *Miller*, 538 U.S. at 331-32.

statute provided that “a health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.”<sup>178</sup> The second statute required that “[a] health benefit plan that includes chiropractic benefits shall . . . [p]ermit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.”<sup>179</sup>

A group of Kentucky HMOs filed suit against the Commissioner of Kentucky’s Department of Insurance, in the Eastern District of Kentucky requesting AWP statutes be declared preempted by ERISA.<sup>180</sup> Following the District Court’s grant of partial summary judgment to defendant,<sup>181</sup> and affirmation by the Court of Appeals,<sup>182</sup> plaintiffs successfully petitioned for a writ of certiorari.<sup>183</sup>

Justice Scalia, delivering the opinion for a unanimous Court, affirmed the judgment of the Court of Appeals, holding that the AWP statutes were valid under ERISA’s savings clause.<sup>184</sup> Scalia also simplified a previously existing ERISA preemption test from a two-step, multi-prong analysis to a straightforward two-part analysis:

[F]or a state law to be deemed a ‘law . . . which regulates insurance’ under ERISA’s savings clause, it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. Second, the state law must substantially affect the risk pooling arrangement between the insurer and the insured.<sup>185</sup>

This two-part preemption analysis has been applied to challenges to other states’ mental parity laws that appear to be directed toward insurance companies, and these statutes have survived preemption.<sup>186</sup>

---

178. § 304.17A-270.

179. § 304.17A-171(2).

180. *Health Maint. Org. Ass’n of Ky., Inc. v. Nichols*, No. Civ. A. 97-24, 1998 WL 34103663, at \*1 (E.D. Ky. Aug. 6, 1998) *aff’d sub nom.* *Ky. Ass’n of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. (2000), *aff’d sub nom. Miller*, 538 U.S. 329.

181. *Id.* at \*10.

182. *Ky. Ass’n of Health Plans*, 227 F.3d at 372, *aff’d sub nom. Miller*, 538 U.S. 329.

183. *Petition for Writ of Certiorari, Ky. Ass’n of Health Plans*, 536 U.S. 956 (No. 00-1471).

184. *Miller*, 538 U.S. at 334, 341-42.

185. *Id.* at 341-42 (citations omitted).

186. *See, e.g.,* *Thompkins v. BC Life & Health Ins. Co.*, 414 F. Supp. 2d 953, 958 n.4 (C.D. Cal. 2006) (citing *Miller*, 538 U.S. 329); *Prudential Ins. Co. of Am. v. Nat’l Park Med. Ctr., Inc.*,

*ERISA Preemption of Damages for Withholding Benefits*

Although there is little chance, if any at all, that New York's Timothy's Law would be broadly preempted by the national ERISA legislation, it is still possible for recovery of damages under the new law to be preempted. In *Pilot Life Insurance Co. v. Dedeaux*,<sup>187</sup> the Court held that state common law causes of action arising from the improper processing of a claim are preempted by federal law.<sup>188</sup> Therefore, where a claimant has been injured by improper handling or processing of a claim arising under an employee benefits plan, he or she may be preempted from recovering damages because the suit falls within the preemption of ERISA.<sup>189</sup> This case set the precedent to "bar state court damages suits against private-sector employee health plans for injuries due to a plan's coverage denial or delay."<sup>190</sup>

The *Pilot Life* court based its decision on two forms of federal law preemption: 1) the well established doctrine that federal law prevails over a directly conflicting state law; and 2) state common law damages remedies relate to ERISA plans.<sup>191</sup>

First, the Court stated that because ERISA furnishes a remedy under the statute, which is a federal lawsuit to either recover due benefits or to enforce the terms of the plan, those remedies that are not included were purposely excluded because Congress intended to prohibit them.<sup>192</sup> Therefore, an employee cannot sue for "lost wages, pain and suffering or punitive damages" under a state law, because this state law would be in direct conflict with the express intent of ERISA.<sup>193</sup>

Second, the Court held that state common law damages affect the way in which benefits disputes are addressed, which is a plan administration responsibility as defined under the ERISA statute.<sup>194</sup> Therefore, this would again put the state common law in direct conflict with the federal statute.<sup>195</sup> Furthermore, because the common law damages could be sought from institutions other than insurers, the court

---

413 F.3d. 897, 912 (8th Cir. 2005).

187. 481 U.S. 41 (1987).

188. *Id.* at 57 & n.4.

189. *See id.* at 48, 56.

190. PATRICIA A. BUTLER, STATE COVERAGE INITIATIVES, ERISA PREEMPTION MANUAL FOR STATE HEALTH POLICYMAKERS 24 (2000).

191. *Id.*; *Pilot Life*, 481 U.S. at 45, 47-48.

192. BUTLER, *supra* note 190, at 24; *see Pilot Life*, 481 U.S. at 54.

193. BUTLER, *supra* note 190, at 24.

194. *Id.*

195. *Id.*

found that the law could not be saved from preemption as being directed at the insurance business.<sup>196</sup> Several federal courts have since applied this reasoning in cases to “prohibit damages suits by health plan enrollees injured by health plan coverage denials and delays.”<sup>197</sup>

In *Spain v. Aetna Life Insurance Co.*,<sup>198</sup> the courts applied the holding of the court from *Pilot Life*, and ruled that the claimant’s suit for recovery of wrongful death benefits was preempted by ERISA because they arose from the mishandling of a claim under an employee benefits plan.<sup>199</sup> In *Spain*, the decedent, Steven Spain, received approval from his insurance company for a three part surgical procedure to treat his cancer diagnosis.<sup>200</sup> The insurance company later withdrew approval for the third stage of the procedure, and as a result, Steven died.<sup>201</sup> His wife and daughter sued the insurance company for wrongful death recovery.<sup>202</sup>

The *Spain* Court reasoned that Steven’s wife and daughter were pre-empted from wrongful death recovery; they stated that “ERISA preempts [a]ppellants’ wrongful death action because the state law in its application directly ‘relates to’ the administration and disbursement of ERISA plan benefits.”<sup>203</sup> ERISA’s preemption clause “is deliberately expansive”<sup>204</sup> and “contains one of the broadest preemption clauses ever enacted by Congress.”<sup>205</sup> Thus, a state cause of action, such as a wrongful death claim, “relates to an ERISA benefit plan when operation of the law impinges on the functioning of an ERISA plan.”<sup>206</sup> In *Spain*,

---

196. *Id.*

197. *Id.*; see, e.g., *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 53-55 (D. Mass. 1997); *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1328-29, 39 (5th Cir. 1992); *Danca v. Private Healthcare Sys., Inc.*, 185 F.3d 1, 7 (1st Cir. 1999); *Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999); *Kuhl v. Lincoln Nat’l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 302 (8th Cir. 1992); *Nealy v. U.S. Healthcare HMO*, 844 F. Supp. 966, 971 (S.D.N.Y. 1994); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993); *Tolton v. Am. Biodyne, Inc.*, 48 F.3d 937, 941-42 (6th Cir. 1995); *Turner v. Fallon Cmty. Health Plan Inc.*, 127 F.3d 196, 199 (1st Cir. 1997) (citations omitted).

198. *Spain*, 11 F.3d 129.

199. *Id.* at 131.

200. *Id.*

201. *Id.* After withdrawing approval for the third part of the surgical procedure, the insurance company admitted its mistake and regranted the approval. *Id.* However, the window of opportunity to successfully complete the procedure had passed. *Id.*

202. *Id.*

203. *Id.*

204. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987).

205. *Greany v. W. Farm Bureau Life Ins. Co.*, 973 F.2d 812, 817 (9th Cir. 1992) (quoting *PM Group Life Ins. Co. v. W. Growers Assurance Trust*, 953 F.2d 543, 545 (9th Cir. 1992)).

206. *Spain*, 11 F.3d at 131 (citing *Metro. Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985)).

because the appellants' wrongful death action directly related to the administration and disbursement of ERISA plan benefits, it impinged on the functioning of an ERISA plan.

The Spains' wrongful death action also could not be salvaged under ERISA's saving clause, which is an exception created by Congress for "any law of any [s]tate which regulates insurance, banking, or securities."<sup>207</sup> The wrongful death cause of action is a general tort claim, and as such is not specifically tailored by the state to regulate insurance.<sup>208</sup> Therefore, although the appellants' wrongful death claim arose under insurance law, specifically the improper withholding of necessary treatment that should have been covered by the insurance company, the action of withholding benefits was a tort, which is not exempt from ERISA preemption.

ERISA specifically states the limited types of recovery that an individual claimant is entitled to bring in an enforcement action against an insurance company.<sup>209</sup> An individual may bring a civil claim to: "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."<sup>210</sup> Therefore, any other types of claims, including punitive damages and claims arising under state law causes of action, such as a wrongful death claim, are preempted by ERISA.<sup>211</sup> Accordingly, if insurance benefits are wrongly withheld, and an insurance beneficiary is injured as a result, a claim can be brought to enforce the administration of the benefits, and to ensure that the benefits are continued in the future, but the insurance company cannot be sued for punitive damages or any other damages arising under state law causes of action.

#### *ERISA Preemption of Damages for Medical Malpractice*

Although the courts have held that the recovery of damages for withholding or delaying benefits is preempted, in recent years they have begun to distinguish these cases from those brought for medical

---

207. 29 U.S.C.A. § 1144(b)(2)(A) (2002) (amendment to original).

208. *Spain*, 11 F.3d at 132.

209. *See* Employee Retirement Income Security Act § 502(a)(1)(A)-(B), 29 U.S.C. § 1132(a)(1)(A)-(B) (2000).

210. § 1132 (a)(1)(B).

211. *See, e.g., Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324, 1332 (5th Cir. 1992) (construing ERISA to preempt the state law claim of wrongful death).

malpractice and negligence.<sup>212</sup> As stated in the ERISA preemption Manual for State Health Policy Makers, “most courts now hold that ERISA does not preempt state court lawsuits against health plans for their traditional legal responsibility for medical errors in diagnosis or treatment of clinicians they employ or who act as their agents.”<sup>213</sup> The courts reason that these cases have to do with the “quality of care,” not the “quantity of care,” and therefore they fall within the traditional area of state authority: tort suits involving the quality of medical care.<sup>214</sup>

In *Petrovich v. Share Health Plan of Illinois, Inc.*,<sup>215</sup> the plaintiff filed suit against her doctor, her HMO, and others, alleging medical malpractice.<sup>216</sup> The plaintiff went to various doctors under her HMO plan displaying numerous symptoms that indicated oral cancer.<sup>217</sup> Despite sending the plaintiff for numerous tests, including an MRI that imaged the plaintiff’s mouth, but which failed to include the painful, irritated area, the doctors negligently failed to diagnose the plaintiff’s oral cancer until nearly a year after her initial visit.<sup>218</sup> The plaintiff died as a result.<sup>219</sup> The plaintiff’s HMO claimed that they could not be named as a defendant in the case because their doctors were considered independent contractors.<sup>220</sup> The court rejected this claim and held that an HMO could be liable for their physicians’ negligence.<sup>221</sup>

The *Petrovich* holding was important for two reasons. First, the Supreme Court expressly held that an HMO may be held vicariously liable for the negligence of its independent-contractor physicians under the doctrine of apparent authority,<sup>222</sup> a holding that overruled the precedent set in *Raglin v. HMO Illinois*.<sup>223</sup> Under *Raglin*, the Illinois Appellate Court had previously stated that neither a health insurer nor its

---

212. BUTLER, *supra* note 190, at 83.

213. *Id.* “These cases are based on the tort principle of respondeat superior, [where] the employer is responsible for the negligence of its employees and agents acting within the scope of their employment or agency.” *Id.* at 87 n.35. See, e.g., *Haas v. Group Health Plan, Inc.*, 875 F. Supp. 544, 549 (S.D. Ill. 1994); *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756, 775 (Ill. 1999). See also Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625, 628 (2001).

214. BUTLER, *supra* note 190, at 83.

215. 719 N.E.2d 756 (Ill. 1999).

216. *Id.* at 760.

217. *Id.* at 761.

218. *Id.*

219. *Id.* at 760.

220. *Id.* at 760-61.

221. *Id.* at 760, 775.

222. *Id.*; see also *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1235 (1988); *supra* note 208 and accompanying text.

223. 595 N.E.2d 153 (Ill. 1992).

HMO subsidiary could be held vicariously liable for the negligence of doctors under contract with them to provide medical services to a member of a health care plan.<sup>224</sup>

Second, the *Petrovich* court held that liability may also be imposed under the doctrine of implied authority.<sup>225</sup> The court stated that the doctrine of implied authority could be used against an HMO to nullify a physician's position as an independent contractor.<sup>226</sup> Further, they held that "an implied agency existed where the facts and circumstances demonstrated that an HMO exerted such control over a participating doctor so as to negate that physician's status as an independent contractor, at least with respect to third parties."<sup>227</sup>

The holding by the *Petrovich* court, that an HMO could be held liable for the medical malpractice of its employed physicians, opened the door for suits arising under employee benefits plans. "[HMO's] provide health care services through employer-sponsored group insurance plans and had previously been covered by ERISA preemption."<sup>228</sup> However, as stated by the Supreme Court, the basic thrust of the pre-emption clause in ERISA was "to avoid multiplicity of regulation to permit the nationally uniform administration of employee benefit plans,"<sup>229</sup> and "in the field of health care . . . there is no ERISA preemption without clear manifestation of congressional purpose."<sup>230</sup> As a result, courts have begun to differentiate cases arising as a result of physician malpractice under HMO and employer-sponsored group health plans from those that arise as a result of a denial of coverage, which continue to be preempted by ERISA.<sup>231</sup>

---

224. *Id.* at 153; *see also* Chase v. Indep. Practice Ass'n., Inc., 583 N.E.2d 251 (Ill. 1991).

225. 719 N.E.2d at 775. Apparent authority, or ostensible authority, is the basis for vicarious liability; this is doctrine under which a contractor may be held vicariously liable for an individual acting as an agent or employee where the liability is based on the authority that the contractor or employer gives to that agent or employee. *Id.* at 765. Implied authority, however, can be described as actual authority established circumstantially; it arises where "the facts and circumstances show that the defendant exerted sufficient control over the alleged agent so as to negate that person's status as an independent contractor, at least with respect to third parties." *Id.* at 770.

226. *Id.* at 772.

227. *Id.*

228. Epstein & Sykes, *supra* note 213, at 629.

229. N.Y. State Conference of Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645, 657 (1995).

230. Pegram v. Herdrich, 530 U.S. 211, 237 (2000) (referring to *Blue Cross & Blue Shield*, 514 U.S. at 654-55).

231. Compare *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 361 (3d Cir. 1995) (ERISA did not preempt vicarious liability claims), with *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52, 53-54 (1987) (ERISA preempts any state law causes of action for denial of benefits and does not permit punitive damages).

*The Possibility of Preemption of Damages under Timothy's Law*

Timothy's Law had received some resistance from the New York State Senate prior to the legislation's passing. Timothy's Law had been passed by the New York State Assembly four years in a row while the Senate ignored the bill.<sup>232</sup> In the 2006 legislative session, the Senate agreed to pass the bill with some alterations.<sup>233</sup> The inclusion of "substance abuse" in the list of mental disabilities and illnesses covered by the bill had to be taken out of the language.<sup>234</sup> As a result of this alteration, dependency on drugs and alcohol was not included in Timothy's Law, and insurance companies may continue to discriminate against these illnesses with regard to insurance coverage.

The exclusion of substance abuse from the protected class of mental illnesses and disabilities in Timothy's Law has the potential to create problems for individuals who receive their insurance coverage through employee benefit plans. Drawing a parallel analysis to what happened in the *Spain* case, if an insurance company first approves, then denies coverage for an illness they claim to be substance abuse, but which actually is the effect of a mental illness or disability, an insured may be barred from recovering damages under state law.

To examine the problem, consider a hypothetical case: an individual in New York has been diagnosed with a mental illness like schizophrenia. The insurance company approves treatment as necessitated by Timothy's Law. The individual then proceeds to receive treatment through antipsychotic or neuroleptic medications.<sup>235</sup> However, there is a strong likelihood that persons with schizophrenia will develop coexisting substance abuse problems as a result of their illness which may increase the risk of mental relapses.<sup>236</sup>

To cleanse the body of addiction, the individual might have to

---

232. Timothy's Law, [http://www.timothyslaw.org/event\\_review.php?ID=7](http://www.timothyslaw.org/event_review.php?ID=7) (last visited July 11, 2008).

233. Shelly Nortz, Agreement Reached on Timothy's Law, NAMI-NYS NEWS, 2006, available at <http://www.naminy.org/timeagreement.html>. In New York, the same versions of a bill with exact language must be passed in both the Senate and Assembly before it can be forwarded to the Governor to be signed. New York State Senate, About the Senate: How a Bill Becomes a Law in New York State, [http://www.senate.state.ny.us/sws/aboutsenate/how\\_idea\\_becomes\\_law.html](http://www.senate.state.ny.us/sws/aboutsenate/how_idea_becomes_law.html) [hereinafter How a Bill Becomes a Law] (last visited July 16, 2008).

234. How a Bill Becomes a Law; see also Timothy's Law, *supra* note 1.

235. See Medline Plus Medical Encyclopedia, *Schizophrenia*, <http://www.nlm.nih.gov/medlineplus/ency/article/000928.htm> (last updated Feb. 26, 2008) (stating that these types of drugs often are the standard method of treatment for schizophrenia).

236. *Id.*



undergo detoxifying treatment. However, the insurance company refuses to cover the cost of the treatment to cleanse the body and aid in the treatment of the mental disorder because the insurance company claims that it is not covered and does not require equal coverage under Timothy's Law. Even if the insurance company was later found to have wrongly withheld this treatment from the individual, under the *Spain* holding, the individual would not be able to recover damages for their losses, or even death, as a result of this error.<sup>237</sup> Any state law claim resulting from an employee benefit plan would be preempted by ERISA.<sup>238</sup> Therefore, any gaps in coverage permitted under Timothy's Law increases the likelihood that insurance benefits can be wrongly withheld and damages arising under such errors could be preempted.

#### *Necessity of New Federal Legislation*

While ERISA preemption has been the cause of states' frustration regarding the passing of new employee benefits laws and allowing for remedies under state insurance laws, this was not the intent of Congress when ERISA was passed.<sup>239</sup> "At the time of its enactment, ERISA *did* provide an adequate remedy when benefits were wrongfully denied."<sup>240</sup> The current gap in the ability to obtain a remedy for the denial of benefits is "[not attributable] to an overboard application of ERISA's preemption clause, but rather to [Congress' failure] to amend ERISA's civil enforcement provision to keep pace with the changing realities of the health care system."<sup>241</sup>

When ERISA was passed in 1974, the predominate type of insurance plan was the traditional fee-for-service plan.<sup>242</sup> Under a fee-for-service plan, beneficiaries who were sick or injured would go to their

---

237. See *Spain*, 11 F.3d 129.

238. *Id.*

239. See generally, *Commercial Mortgage Ins. Inc. v. Citizens Nat'l Bank of Dallas*, 526 F. Supp. 510, 514-19 (D.C. Tex. 1981) (discussing legislative intent of Congress through an examination of the legislative history of ERISA); *Gillis v. Hoechst Celanese Corp.*, 4 F.3d 1137, 1148 (3d Cir. 1993) (citing *Firestone Tire & Rubber Co. v. Bruch*, 495 U.S. 101, 118) (finding that "Congress' purpose in enacting the ERISA . . . provisions [was to] ensure[] that the 'individual participant knows exactly where he stands with respect to the plan.'"); *Pension Ben. Guar. Corp. v. R.A. Gray & Co.*, 467 U.S. 717, 730-34 (1984) (analyzing Congress' intent in enacting ERISA); 70 C.J.S. *Pensions* § 13 (2006) (explaining that one of the purposes of Congress' in adopting ERISA was the furtherance of retirement benefit plans).

240. *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 58 (D. Mass. 1997).

241. *Id.*

242. *Id.* (citing Kent G. Rutter, *Democratizing HMO Regulation to Enforce the 'Rule of Rescue'*, 30 MICH. J. L. REFORM 147, 171 (1996)).

doctor, receive treatment, and then send their bill to their insurer.<sup>243</sup> If their insurer wrongfully or improperly refused to reimburse them, the beneficiaries could initiate suit and recover the cost of their treatment, pursuant to the remedies available under ERISA.<sup>244</sup> However, as discussed above, in today's employee benefits arena, the remedies available under ERISA can no longer make beneficiaries whole. In light of this, new federal legislation is necessary if this issue is to be fully resolved. Currently, the preemption clause can only be definitively interpreted by the courts.<sup>245</sup>

However, as is the case with many social issues that make their way into the political arena, state governments have been far more progressive than the federal government when confronting issues of mental health parity in healthcare. As previously discussed throughout this note, states' governments have been passing new legislation, continually trying to get around ERISA preemption, to bring broader and better healthcare coverage to individuals whose benefits are derived from employer benefits plans.

## PART VI

### *Progressivism: State Governments versus the Federal Government*

Some scholars contend that state legislatures, not Congress, are perhaps in the best situation to protect the Constitutional rights of individuals.<sup>246</sup> They assert that "state governments are uniquely responsive to smaller politically progressive groups, and that limitations on federal power are justified . . . to preserve progressive local legislation."<sup>247</sup> This is because state and local governments are closer to their individual citizens, and as such, are likely to be more liberal when protecting individual rights and addressing individual issues than the

---

243. *Id.* (noted in Christopher Wethly, New York Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.: *Vicarious Liability Malpractice Claims Against Managed Care Organizations Escaping ERISA's Grasp*, 37 B.C. L. REV. 813, 817 (1996)).

244. *Id.* (construing Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1132(a)(1)(B) (2000)).

245. See BUTLER, *supra* note 190, at 6.

246. Denise Z. Morgan & Rebecca E. Zietlow, *The New Parity Debate: Congress and Rights of Belonging*, 73 U. CIN. L. REV. 1347, 1376 (2005) (citing Stephen Clark, *Progressive Federalism? A Gay Liberationist Perspective*, 66 ALB. L. REV. 719, 755-57).

247. *Id.*

federal government.<sup>248</sup> Therefore, they should be able to freely protect those individuals without intrusion from the federal government.<sup>249</sup> Currently, if there were such justified limitations on federal power, the states would be free to legislate without concerns regarding ERISA preemption of states' employee benefits plans statutes and preemption of damages under such statutes.

When progressive reform movements start at the state level, and then subsequently generate national support, they are less likely to be resisted at the national level.<sup>250</sup> This is because these movements create changes that are accepted over time, becoming societal norms; this change and eventual acceptance is much different than "top down changes imposed by Congress."<sup>251</sup>

One example of this kind of state reform movement is the gay rights movement. One scholar points out that there are several urban centers, in certain areas of the country, which have attracted many gay men and lesbian women because they offer stronger protection of sexual minorities' rights.<sup>252</sup> By converging their specific minority group in concentrated areas, they have become more influential and have been able to lobby for favorable legislation which would otherwise not be enacted at the national level.<sup>253</sup>

The history of the Timothy's Law legislation is similar and constitutes evidence of this theory of progressivism. Timothy's Law was a direct result of the drive and motivation of the O'Clairs after Timothy O'Clair's death.<sup>254</sup> Because of the support that the mental health parity issue received, the New York Legislature responded and Timothy's Law legislation was drafted.<sup>255</sup> Although this legislation took several years to pass in the Senate, it finally passed in a special Congressional session

---

248. *Id.* at 1380 (citations omitted) (arguing that state governments tend to be more progressive because of the strong tradition of democratic activism and explaining that there is a greater opportunity to interact and participate in state government because of the smaller political communities, thereby making those governments more accountable to the people they serve). *Id.* at 1379-80; see also Robert Justin Lipkin, *Foreward* to Symposium, *Is American Progressive Constitutionalism Dead?*, 4 WIDENER L. SYMP. J. i, at iii-v (1999).

249. *Id.* at 1376.

250. *Id.* at 1380 (citations omitted).

251. *Id.*

252. See *id.* at 1378-79 (citing Steven Clark, *Progressive Federalism? A Gay Liberationist Perspective*, 66 ALB. L. REV. 719, 722 (2003)).

253. See *id.* at 1379 (citing Mark C. Gordon, *Differing Paradigms, Similar Flaws: Constructing a New Approach to Federalism in Congress and the Court*, 14 YALE L. & POL'Y REV. 187, 218 (1996)).

254. Timothy's Law, *supra* note 1.

255. See *id.*

called late in 2006.<sup>256</sup> This demonstrates how the political accountability of the state governments can have a big impact on their progressivism.

### *The Circular Problem of Preemption*

Even where state governments are more progressive than the federal government and pass legislation early to tackle social, economic and political issues, the circular problem of pre-emption still exists when Congress comes in and later passes federal policy. Preemption can be an issue even where Congress has not expressly stated that a state law should be preempted by federal.<sup>257</sup> Courts have held that even without “explicit preemptive language,” Congress’ desire to preempt state law may still be found.<sup>258</sup> This is called implied conflict preemption and “occurs where a federal statute implicitly overrides a state law” by either an intent by Congress for only the federal law to occupy the specific field, or when there is an actual conflict between the state and federal laws.<sup>259</sup> Implied conflict preemption can occur even where Congress has not entirely superceded state regulation in an area—a state law will be “preempted [sic] to the extent that it actually conflicts with federal law.”<sup>260</sup>

An even more alarming application of preemption occurs where the Court holds that a state law may be preempted by a federal statute contrary to the expressed intent of the statute and against the statute’s savings clause. In *Geier v. American Honda Motor Co.*,<sup>261</sup> the Court held that the plaintiff’s state common law claim was preempted by a federal statute, even though that federal statute contained a savings clause aimed

---

256. Press Release, the Senate Republican Majority, Senate Passes “Timothy’s Law to Provide Mental Health Parity” (Sept. 15, 2006), <http://www.senate.state.ny.us/pressreleases.nsf/> (search “PRbyDate” hyperlink; then follow “2006” hyperlink).

257. Morgan, *supra* note 246, at 1386; (citing *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 204 (1983)).

258. *Pac. Gas & Elec. Co.*, 461 U.S. at 203-04.

259. *Turner v. Chevron U.S.A. Inc.*, No. B173622, 2006 WL 1314013, at \*6 (Cal. Ct. App. 2006) (citing *Freightliner Corp. v. Myrick*, 514 U.S. 280, 287 (1995) (stating that “a federal statute implicitly overrides state law either when the scope of a statute indicates that Congress intended federal law to occupy a field exclusively or when state law is in actual conflict with federal law.”)).

260. *Pac. Gas & Elec. Co.*, 461 U.S. at 204. The court further stated that a state statute will be found to conflict with federal legislation where “compliance with both federal and state regulations is a physical impossibility.” *Id.* (quoting *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963)). Further, the Court held that a conflict may also exist where state law “stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.” *Id.* (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67-68 (1941)).

261. 529 U.S. 861 (2000).

at protecting state common law actions from preemption.<sup>262</sup> “Apparently, implied preemption is a real threat even when Congress explicitly states its intent not to preempt.”<sup>263</sup> Similarly, in *Copollone v. Liggett Group, Inc.*,<sup>264</sup> the Court discussed the familiar principle of *expressio unius est exclusio alterius*, which states that “Congress’ enactment of a provision defining the pre-emptive reach of a statute implies that matters beyond that reach are not pre-empted.”<sup>265</sup> However the Court then went on to state that if “federal law so thoroughly occupies a legislative field ‘as to make reasonable the inference that Congress left no room for the States to supplement it,’” then that state law is preempted.<sup>266</sup>

Although we have previously examined the possibility of Timothy’s Law preemption as it relates to ERISA, a new federal policy could supersede established state legislation, including New York’s Timothy’s Law. The legislation, called The Mental Health Parity Act of 2007, was introduced in the 110th Congress and, if passed, has the potential to displace other states’ mental health parity laws, regardless of which legislation provides more or better mental health coverage.<sup>267</sup>

Under the analysis of preemption, it would be necessary for The Mental Health Parity Act of 2007 to include a savings clause identifying the specific intent of Congress not to supersede or preempt state law actions arising under the mental health parity laws of the independent states. However, in light of the *Geier* and *Copollone* Courts’ holdings, there is always a chance that the Mental Health Parity Act of 2007 could

---

262. *Id.* at 867, 869. The savings clause in the federal act at issue stated “[c]ompliance with a [motor vehicle] safety standard prescribed under this chapter does not exempt a person from any liability at [state] common law.” *Id.* at 868. The Court found that conflict preemption . . . “turns on the identification of ‘actual conflict,’ and not on an express statement of pre-emptive intent.” *Id.* at 884. *See also* *Burt v. Fumigation Serv. & Supply, Inc.*, 926 F. Supp. 624, 627, 630 (W.D. Mich. 1996) (where victims of methyl bromide fumigation brought state law causes of action, the Court held that some of those claims were preempted by 7 U.S.C.A. § 136v because the claims fall within the Congressional intent to preempt state law labeling or packaging requirements); *Gomez v. St. Jude Med. Diag Div. Inc.*, 442 F.3d 919, 927-28 (5th Cir. 2006) (holding that a Louisiana patient’s state law claims regarding the defective design of a medical device were preempted by the Medical Device Amendments of 1976 to the Food, Drug, and Cosmetics Act because the manufacturer had obtained the premarket approval on the product design from the Food and Drug Administration).

263. *Morgan*, *supra* note 246, at 1386. The *Geier* Court also found that an express preemption clause does not foreclose implied conflict preemption. *Geier*, 529 U.S. at 869.

264. 505 U.S. 504 (1992).

265. *Id.* at 517.

266. *Id.* at 516 (citing *Fidelity Fed. Sav. & Loan Ass’n v. De la Cuesta*, 458 U.S. 141, 153 (1982)).

267. Mental Health Parity Act of 2007, S. 558, 110th Cong. (2007), available at <http://thomas.loc.gov/cgi-bin/query/z?c110:S.558>.

be found to preempt state law causes of action if the Courts hold that the individual state laws conflict or aggravate the intent of the federal legislation.

#### CONCLUSION

Timothy's Law will benefit many New Yorkers, enabling them to receive mental health treatment previously unavailable or out of their financial reach. Although Timothy's Law will not be preempted by ERISA because it falls under the insurance savings clause, the preemption of damages for withholding benefits is still a possibility for insurees. The overabundance of progressive state mental health parity laws may soon move Congress to enact a truly comprehensive mental health parity law, standardizing health care benefits for covered people throughout the country. The effect of this federal law on the various state parity laws will not be known until such a law is actually passed.

The clear majority of studies on mental health parity laws have shown that they will not cause excessive financial burdens on insurers, employers, or employees. The scientific data has conversely led some researchers to conclude that the opposite would occur: providing adequate mental health care for employees will result in savings. The actual impact of Timothy's Law will not be known for many years, leaving many questions unanswered in the interim.

*Desireè Busching\* & Simon Kapochunas\*\**

---

\* J.D., 2008, Hofstra University School of Law.

\*\* J.D., 2008, Hofstra University School of Law.