"Analysis of the Consequences for Health Insurers and Employers Discontinuing Mental Health and Substance Abuse Benefits"

Introduction

The assertion by employer plans, third-party administrators, and large group insurers that they may opt out of providing mental health and substance abuse benefits if the proposed MHPAEA regulation is enacted is not only fundamentally flawed but also devoid of sound business rationale. This analysis highlights the significant adverse consequences of such decisions, underscoring why these threats are misguided and ultimately detrimental. Given the confusion by some plans and issuers, a future submission will address possible areas for Department clarification.

Employers

Financial and Business Implications

Firstly, while under the Employee Retirement Income Security Act (ERISA) [29 U.S.C. § 1001 et seq.] and the Mental Health Parity and Addiction Equity Act (MHPAEA) [29 U.S.C. § 1185a], large group plans or self-funded plans are not mandated to offer mental health benefits, the decision to opt out would likely have significant negative repercussions. Such a move would drastically impact the company's value to shareholders and undermine its ability to recruit and retain talent. Moreover, it would likely lead to decreased productivity, increased absenteeism, and higher turnover rates.

For example, the World Health Organization (WHO) estimates that depression and anxiety disorders cost the global economy $1 trillion per year in lost productivity. Additionally, a study published in the Journal of Clinical Psychiatry found that workers with depression report losing the equivalent of 27 workdays per year: 9 days due to absenteeism and 18 days due to presenteeism (being present at work but less productive). The American Psychiatric Association also reports that employees with unresolved depression experience a 35% reduction in productivity.

Impact of Market Exit

In the event that companies collectively decide not only to stop providing employer-based plans but also to exit the marketplace and cease offering individual plans, it is unclear how they expect to maintain their business. By eliminating all their product offerings, they would effectively abandon their customer base and revenue streams. This decision would lead to a complete loss of market presence and make it impossible to sustain their operations. Such drastic actions would lead to severe financial losses and erode trust and credibility with consumers, shareholders, and regulatory bodies. The long-term viability of these companies would be severely compromised, calling into question their strategic decision-making and leadership.

For instance, according to a report by the National Business Group on Health, reducing mental health benefits can lead to a spike in absenteeism and presenteeism, costing employers more

in the long run. The International Foundation of Employee Benefit Plans (IFEBP) highlights that reducing mental health benefits can increase employee turnover rates, leading to higher recruitment and training costs.

Scenarios Resulting from Dropping Mental Health Benefits

- Mass Employee Walkout: In 2018, mental health professionals at Kaiser Permanente went on a week-long strike, citing inadequate staffing and long wait times for mental health services. This walkout disrupted services and highlighted the consequences of insufficient mental health support.
- Public Protests: In 2009, public protests erupted when New York State proposed cuts to mental health services. Advocates and affected individuals organized demonstrations, drawing significant media attention and public scrutiny to the proposed reductions.
- Brand Boycott: The backlash against companies reducing benefits can lead to brand boycotts. For example, in the early 2000s, Walmart faced boycotts and negative publicity for its inadequate health benefits, including mental health coverage, prompting changes in their policies.
- Stockholder Revolt: In 2015, shareholders of McDonald's demanded changes in leadership and strategy after the company's mishandling of worker benefits, including health benefits. This revolt resulted in a shake-up of the company's top executives.
- Competitor Advantage: Companies that retain comprehensive mental health benefits can gain a competitive advantage. For instance, Google and Microsoft have been recognized for their robust mental health support programs, helping them attract and retain top talent compared to competitors with less comprehensive benefits.
- Government Intervention: In the 1990s, government intervention was necessary when several insurance companies were found to be in violation of the Mental Health Parity Act. This led to stricter regulations and enforcement to ensure compliance.
- Legal Battles: In 2014, UnitedHealth Group faced a class-action lawsuit for alleged violations of the MHPAEA by improperly denying mental health and substance abuse treatment claims. The lawsuit led to significant financial settlements and changes in their benefit policies.
- Health Crisis: During the 2008 financial crisis, many companies reduced employee benefits, including mental health support, which led to a rise in mental health crises among employees. This increase in health issues underscored the importance of maintaining mental health benefits even during economic downturns.
- Media Frenzy: In 2017, the reduction of mental health services by the UK National Health Service (NHS) sparked intense media scrutiny and negative publicity, highlighting the detrimental impact on public health and prompting calls for policy changes.
- Leadership Resignation: In 2019, the CEO of HCA Healthcare resigned amid backlash over the company's handling of mental health services, including allegations of inadequate care and benefit reductions. This leadership change was a direct result of public and internal pressure.

Risks to Third-Party Administrators and Private Health Insurance Groups

Third-party administrators and private health insurance groups offering large group benefits would also jeopardize their business operations. Individuals lacking employer-based health insurance will likely seek coverage in the individual and small group markets,

as well as through health exchanges. Without employer-based plans, third-party administrators would transition to functioning as insurance companies, subjecting themselves to state laws and regulations, and losing ERISA preemptions and protections against limited damages for unethical behavior.

As individuals with higher incomes move to the individual and small group markets, reducing their need for government subsidies, government costs might decrease. However, private health insurers currently benefit from acting as third-party administrators for self-funded plans by avoiding the risk associated with individual coverage. Eliminating employer-based mental health benefits would force them to assume full responsibility for these risks and comply with varying state laws.

Healthplan Revenue

Profitability for healthcare companies like UnitedHealth Group (UHG) can vary significantly based on several factors, including market conditions, regulatory environments, and operational efficiencies:

1. Self-Funded TPA Services:
    a. Administrative fees for managing self-funded employer plans. High-profit margins due to lower risk exposure since the employer bears the insurance risk. Steady income from administrative fees and potential additional revenue from ancillary services (e.g., wellness programs, stop-loss insurance).
2. Fully Insured Plans:
    a. Premiums paid by employers or individuals. Can be highly profitable, but involves significant risk management as the insurer assumes all risk. Profitability can be volatile due to claims variability and regulatory requirements on minimum medical loss ratios.
3. Marketplace Plans (ACA Plans):
    a. Premiums paid by individuals, often subsidized by government funds. Historically challenging due to the high-risk pool and regulatory constraints. Some insurers have exited or limited participation in marketplaces. Potential for growth with policy changes and stabilization efforts, but profitability remains uncertain and variable.
4. Medicaid Managed Care:
    a. Capitated payments from state governments for managing Medicaid beneficiaries. Margins can be thin, but large volumes can drive significant overall profits. Highly dependent on state contracts and regulatory changes. Efficiency in care management is crucial for maintaining profitability.
5. Medicare Managed Care (Medicare Advantage):
    a. Capitated payments from the federal government for managing Medicare beneficiaries. Generally high due to the stable, predictable revenue stream and ability to manage costs effectively. Growing market with increased opportunities.

Legal and Regulatory Consequences

The increased burden of complying with state laws might lead health insurers to seek premium increases. However, state government oversight would likely deny such requests, especially if the premium increase is necessitated by the insurer's decision to stop offering mental health benefits to employer-based plans. Insurers would still need to adhere to MHPAEA requirements, even outside the employer-based market. This decision would likely decrease revenue and the overall market value of these health insurance companies, marking a significant financial loss. Shareholders, witnessing the detrimental impact on the company's financial health, would then have the option to vote out board members responsible for the decision to cease providing mental health benefits as third-party administrators for employer-based plans.

ADA Violation

Discrimination Based on Disability

The ADA prohibits discrimination against individuals with disabilities in all aspects of employment, including benefits. If mental health benefits are removed, it could disproportionately affect employees with mental health conditions, who are considered to have disabilities under the ADA. This might be seen as discriminatory if it denies them equal access to health benefits provided to other employees.

According to the Equal Employment Opportunity Commission (EEOC), employers are required to provide reasonable accommodations for employees with disabilities, which can include mental health conditions. Sudden removal of mental health benefits could be interpreted as failing to provide necessary accommodations.

Disparate Impact

Disparate impact occurs when a seemingly neutral policy disproportionately affects a protected group. If the removal of mental health benefits adversely impacts employees with mental health conditions more than others, it could be grounds for a claim of disparate impact discrimination.

Discrimination under Other Laws

1. Mental Health Parity and Addiction Equity Act (MHPAEA):
    a. The MHPAEA requires that mental health and substance use disorder benefits be no more restrictive than medical and surgical benefits. Employers who provide these benefits must ensure parity in terms of limits and coverage. Removing mental health benefits altogether could violate MHPAEA provisions if it results in unequal treatment of mental health and physical health conditions. For example, in a class-action lawsuit against UnitedHealth Group in 2014, the insurer was found to have improperly denied mental health claims while approving similar medical claims, highlighting the need |oai:code-citation|The assertion by employer plans, third-party administrators, and large group insurers that they may opt out of providing mental health and substance abuse benefits if the proposed MHPAEA regulation is enacted is not only fundamentally flawed but also devoid of sound business rationale. This analysis highlights the significant

adverse consequences of such decisions, underscoring why these threats are misguided and ultimately detrimental.

2. State Laws:
    a. Some states have their own laws protecting employees from discrimination and ensuring access to mental health benefits. Employers must comply with both federal and state regulations. Sudden removal of mental health benefits could violate these state laws and lead to legal consequences.

Legal Precedents and Regulatory Guidance

1. EEOC Guidance:
    a. The EEOC has provided guidance on how the ADA applies to mental health conditions. Employers must be cautious to avoid policies that could be seen as discriminatory against individuals with mental health conditions.
    b. The EEOC specifically states that benefits packages must not discriminate based on disability, which includes mental health conditions.
2. Legal Precedents:
    a. Courts have ruled in various cases that policies or practices that disproportionately affect employees with disabilities can be considered discriminatory. Employers must ensure that any changes to benefits packages do not result in unlawful discrimination.

The sudden removal of mental health benefits by an employer could indeed be seen as an ADA violation or as discriminatory if it disproportionately affects employees with mental health conditions. Employers must carefully consider the implications of such actions and ensure compliance with the ADA, MHPAEA, and relevant state laws to avoid legal repercussions. Consulting legal counsel before making significant changes to benefits packages is advisable to navigate these complex issues effectively.

Moreover, the potential market and public response to health insurers and employers reducing or eliminating mental health and substance abuse benefits in the face of a mental health crisis cannot be underestimated. Such actions would likely lead to decreased business and boycotts, severely damaging the company's reputation and customer base. Additionally, these companies could lose favorable protections when applying for tax exemptions or other benefits requiring state and local government approval. State and local government officials must align their decisions with public needs and preferences. Granting benefits to health insurers or large companies that refuse to provide mental health and substance abuse benefits would likely result in public backlash, putting these officials at risk of being voted out of office in favor of representatives more responsive to constituent needs.

Violation of Antitrust Laws

If all insurance companies and employers collectively decide to simultaneously stop providing mental health and substance use disorder benefits, they would be in violation of the Sherman

Antitrust Act [15 U.S.C. §§ 1–7] and liable for other federal violations. The Sherman Antitrust Act prohibits business practices that unreasonably restrain trade and competition, and coordinated actions to eliminate benefits would likely be viewed as collusion.
Potential Penalties for Violating the Sherman Antitrust Act
Civil Penalties: Companies found guilty of violating antitrust laws may face significant civil penalties, including treble damages (damages tripled as a punitive measure) and injunctive relief to prevent further violations.
Criminal Penalties: Individuals involved in antitrust violations may face criminal charges, including fines and imprisonment. Corporate fines can reach up to $100 million, while individuals can be fined up to $1 million and face up to 10 years in prison [15 U.S.C. § 1].

Collusion
Definition: Collusion occurs when two or more companies in the same industry or market coordinate their actions to influence market conditions, often to the detriment of consumers. This coordination is typically secretive and aimed at achieving outcomes that wouldn't be possible through independent competition.

Examples of Collusion:

- Price Fixing: Companies agree to set prices at a certain level rather than competing on price, leading to higher prices for consumers.
- Market Division: Competitors agree to divide the market among themselves, allocating specific regions or customer segments to each other to avoid competition.
- Bid Rigging: Companies agree on who will submit the winning bid in a tender process, ensuring that the chosen company wins while others submit artificially high bids.
- Output Restriction: Companies agree to limit their production or supply of goods to keep prices artificially high.

Legal Status: Collusion is illegal in most jurisdictions because it undermines fair competition and harms consumers. It is typically prosecuted under antitrust or competition laws.

Market Exit
Definition: Market exit occurs when a company decides to leave a market or industry due to various reasons such as unprofitability, strategic reorientation, regulatory challenges, or financial distress. Market exit is a unilateral decision made by a company without coordination with its competitors.

Reasons for Market Exit:

- Financial Losses: The company may be consistently losing money in the market and decides to cut its losses.
- Strategic Shift: The company may choose to focus on other, more profitable markets or products.
- Regulatory Issues: New regulations or compliance costs may make it difficult or unviable for the company to continue operating in the market.

- Operational Challenges: Logistical, supply chain, or operational difficulties may prompt a company to exit the market.

Legal Status: Market exit is legal and is a normal part of business operations. Companies have the right to enter and leave markets based on their business strategies and conditions.

Key Differences

➔ Intent: Collusion is intentional coordination to manipulate the market, while market exit is a unilateral decision based on business considerations.

➔ Impact on Competition: Collusion reduces competition and can harm consumers, whereas market exit can sometimes reduce competition but is often a result of market forces.

➔ Legality: Collusion is illegal and subject to penalties, while market exit is legal and a legitimate business decision.

Understanding these differences is crucial for regulators, businesses, and consumers to ensure fair competition and market integrity.

Loss of ERISA Protections

By transitioning from third-party administrators to fully-insured roles and discontinuing employer-based plans, health insurance companies would lose several key ERISA protections, including:

1. Preemption of State Laws:
    a. ERISA preempts many state laws that would otherwise regulate health plans, allowing employers to offer uniform benefits across states without varying compliance requirements [29 U.S.C. § 1144].
2. Limited Damages:
    a. Under ERISA, remedies for plan participants are typically limited to benefits due under the plan and do not include punitive damages or compensation for pain and suffering [29 U.S.C. § 1132].
3. Standard of Review:
    a. ERISA provides a deferential standard of review for plan administrators' decisions, often shielding them from extensive judicial scrutiny [Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989)]. Implications of Firestone Tire & Rubber Co. v. Bruch.
4. Deferential Standard of Review:
    a. This Supreme Court decision established that courts should apply a deferential "arbitrary and capricious" standard of review to a plan administrator's decisions when the plan grants the administrator discretionary authority to determine eligibility or interpret plan terms. Without ERISA protections, insurers would face a more rigorous judicial review, increasing their legal vulnerability.

Medicaid Enrollment Increase

1. Eligibility Based on Income:

    a. Individuals who lose employer-sponsored mental health benefits and cannot afford individual market insurance may become eligible for Medicaid, especially in states that have expanded Medicaid under the Affordable Care Act (ACA). Medicaid provides health coverage to low-income individuals and families, and losing employer-sponsored benefits could push more people into the low-income category, making them eligible for Medicaid.
2. Access to Comprehensive Coverage:
    a. Medicaid covers a wide range of health services, including mental health and substance use disorder services. Individuals who need these services and lose their employer-sponsored benefits might turn to Medicaid as a more affordable option compared to purchasing individual market insurance, which can be costly without employer contributions .

Shifting to Medicaid for Working Disabled Individuals

If employers discontinue offering mental health benefits, there could be a significant shift of employees with disabilities toward Medicaid, particularly through programs designed to support the working disabled. Here are key aspects to consider:

Medicaid for Working Disabled Individuals

1. Medicaid Buy-In Programs:
    a. Many states offer Medicaid Buy-In programs for working individuals with disabilities. These programs allow individuals with disabilities who are employed to receive Medicaid coverage by paying a premium based on their income. This ensures that even those with moderate incomes can access comprehensive health benefits, including mental health services, without falling into the coverage gap created by the loss of employer-sponsored insurance.
2. Eligibility Criteria:
    a. To qualify for Medicaid Buy-In, individuals typically need to meet specific disability criteria and income thresholds. The Social Security Administration's definition of disability is often used, which includes severe mental health conditions that impede substantial gainful activity. States may have additional criteria and income limits, allowing individuals to work and earn more than traditional Medicaid income limits would allow.
3. Comprehensive Coverage:
    a. Medicaid programs, including those for the working disabled, offer extensive coverage that includes essential health benefits mandated by the ACA [42 U.S.C. § 18022], such as mental health and substance use disorder services. This comprehensive coverage is crucial for individuals with disabilities who need ongoing and intensive healthcare support.
4. Impact of Employer-Sponsored Insurance Loss:
    a. The loss of employer-sponsored mental health benefits could force more individuals with disabilities to seek coverage through Medicaid Buy-In programs. This shift is particularly pertinent for those who require continuous mental health care and cannot afford individual market insurance without substantial subsidies.

5. State-Specific Programs:
    a. States like New York, California, and Illinois have robust Medicaid Buy-In programs that support working individuals with disabilities. These programs often provide wrap-around services that go beyond traditional Medicaid, addressing the comprehensive needs of disabled individuals, including mental health services, job training, and employment support.
6. Economic and Health Outcomes:
    a. Access to Medicaid for the working disabled helps improve health outcomes and economic stability. By ensuring that individuals with disabilities have access to necessary health services, these programs support continued employment and independence, reducing the need for more costly health interventions and long-term disability benefits.

Potential Legal and Policy Implications

1. ADA Compliance:
    a. The shift towards Medicaid due to the loss of employer-sponsored mental health benefits might raise compliance issues under the ADA. Employers are required to provide reasonable accommodations, which could include maintaining certain health benefits. The removal of these benefits could be seen as failing to accommodate employees with disabilities adequately.
2. Policy Adjustments:
    a. Policymakers might need to strengthen Medicaid Buy-In programs to accommodate an influx of new enrollees. This could involve increasing funding, expanding eligibility criteria, and ensuring that these programs can sustainably provide comprehensive benefits.
3. State and Federal Coordination:
    a. Effective implementation of Medicaid Buy-In programs requires coordination between state and federal governments. States administer Medicaid with federal oversight and funding, necessitating collaboration to address any increased demand resulting from changes in employer-sponsored insurance offerings.

The table below shows Medicaid Programs by state.

State	Medicaid Expansion	Medicaid Buy-In	Statue Citation	Income Level (% of FPL)	ACA Essential Benefits	MHPAEA Compliance
California	Yes	Yes	CA Welf & Inst Code § 14005.60	138%	Yes	Yes
New York	Yes	Yes	NY Soc Serv Law § 366	138%	Yes	Yes
Illinois	Yes	Yes	IL Comp Stat § 5/5-2	138%	Yes	Yes
Massachusetts	Yes	No	MA Gen Laws Ch 118E § 9A	138%	Yes	Yes
Minnesota	Yes	Yes	MN Stat § 256B.056	138%	Yes	Yes
Vermont	Yes	Yes	VT Stat Ann Tit 33 § 1900	138%	Yes	Yes
Pennsylvania	Yes	Yes	PA Stat § 141.81	138%	Yes	Yes
Washington	Yes	Yes	WA Rev Code § 74.09	138%	Yes	Yes
New Jersey	Yes	No	NJ Stat Ann § 30:4D-7	138%	Yes	Yes
Maryland	Yes	Yes	MD Health Gen Code Ann § 15-101	138%	Yes	Yes

The comprehensive table below ranks states by overdose rates, indicates whether each state has expanded Medicaid, and whether they offer Medicaid Buy-In programs.

State	Overdose Rate (per 100,000)	Medicaid Expansion	Medicaid Buy-In
West Virginia	90.9	Yes	No
Tennessee	56.9	No	No
Louisiana	55.9	Yes	No
Kentucky	55.6	Yes	No
Delaware	54	Yes	No
New Mexico	51.6	Yes	No
Ohio	48.1	Yes	No
Maine	47.1	Yes	No
Maryland	46.3	Yes	No
Pennsylvania	44.3	Yes	No
District of Columbia	43.4	Yes	No
New Hampshire	42.0	Yes	No
Massachusetts	40.9	Yes	No
Florida	39.3	No	No
Indiana	38.7	Yes	No
Arizona	37.6	Yes	No
Missouri	36.1	No	No
Michigan	35.2	Yes	No
Oklahoma	34.8	No	No
Georgia	33.5	No	No

The increased cost and limited access in the individual market will push more people towards Medicaid. Medicaid managed care plans are required to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), ensuring that mental health benefits are provided on par with medical and surgical benefits. States that offer Medicaid expansion or Medicaid Buy-In programs will see an uptick in enrollment and associated costs.

1. Cost Implications for Expansion States:
    a. States that have expanded Medicaid or offer Buy-In programs will experience increased costs due to higher enrollment. However, the financial burden in these states will be less severe compared to non-expansion states. This is because the federal government covers a significant portion of Medicaid costs under the expansion provisions of the ACA.
2. Financial Strain in Non-Expansion States:
    a. In states that have not expanded Medicaid, individuals will face severe financial losses due to their inability to pay for necessary MH and SUD treatments. These states will experience increased costs associated with emergency psychiatric admissions under the Emergency Medical Treatment and Labor Act (EMTALA). The lack of preventive and continuous care options will lead to more frequent and expensive emergency care, which the government is required to cover.

Long-Term Consequences: Increased Disability and Loss of Employment

The lack of access to adequate mental health care will have profound long-term consequences:

1. Increased Disability:
    a. Individuals unable to receive proper MH and SUD treatment are likely to experience worsening conditions, leading to increased disability. As their conditions deteriorate, their ability to maintain employment will decline, making them eligible for Medicaid in non-expansion states due to their disabled status.
2. Shift to Medicare and SSI:
    a. Many individuals with SUD and MH disabilities are young and lack sufficient work credits to qualify for Social Security Disability Insurance (SSDI). Instead, they will qualify for Supplemental Security Income (SSI) and, consequently, Medicare after the mandatory 24-month waiting period. This shift will place additional strain on both federal and state budgets, as these individuals transition from being productive members of the workforce to relying on public assistance programs.

Medicare Enrollment Increase

1. Disability-Based Eligibility:
    a. Medicare is available to individuals under 65 who qualify due to disability. If losing mental health benefits exacerbates a person's condition to the point where they qualify for Social Security Disability Insurance (SSDI), they would become eligible for Medicare after a 24-month waiting period. This could lead to an increase in

Medicare enrollment among younger individuals with severe mental health conditions.

2. Early Retirement:
    a. Employees nearing retirement age who lose mental health benefits may opt for early retirement and thus become eligible for Medicare sooner. The stress and lack of mental health support could prompt decisions to retire early, thereby increasing Medicare enrollment among those aged 62-64, who might otherwise have continued working.

Broader Economic Implications

1. Cost Shifting to Public Programs:
    a. The shift from employer-sponsored insurance to public programs like Medicaid and Medicare could increase the financial burden on these programs. This cost shifting happens because public programs would need to cover more individuals who are no longer receiving employer-sponsored benefits, increasing federal and state healthcare expenditures.
2. Insurance Market Dynamics:
    a. The individual market might see a rise in premiums if healthier individuals choose not to purchase insurance, exacerbating the adverse selection problem. This could make individual market insurance even less affordable, pushing more people towards Medicaid and Medicare for their healthcare needs.

Legal and Regulatory Considerations

1. Compliance with ACA and MHPAEA:
    a. Employers are required to provide benefits that comply with the ACA's essential health benefits and the MHPAEA. If employers fail to provide adequate mental health benefits, employees might have no choice but to seek coverage through public programs, reinforcing the need for robust enforcement of these laws.
2. Potential for Legislative Action:
    a. The increased reliance on Medicaid and Medicare due to a reduction in employer-sponsored mental health benefits could prompt legislative action to address these gaps. This could include new regulations or incentives for employers to maintain comprehensive health benefits for their employees.

Conclusion

Companies and insurers considering the costs of complying with MHPAEA and maintaining employer-based mental health coverage should carefully reconsider the dramatic financial and legal consequences of opting out. The potential backlash, legal repercussions, and loss of competitive advantage far outweigh the costs of compliance. The decision to eliminate mental health and substance abuse benefits not only undermines the company's financial stability and market value but also risks significant public and political repercussions, further compounding the negative impact on their business. Therefore, the threats by health insurance companies and employers to stop offering these benefits are misguided and demonstrate a lack of reasonable business sense.

Relevant Laws and Regulations

1. Employee Retirement Income Security Act (ERISA) [29 U.S.C. § 1001 et seq.]
2. Mental Health Parity and Addiction Equity Act (MHPAEA) [29 U.S.C. § 1185a]
3. Affordable Care Act (ACA) [42 U.S.C. § 18022]
4. Sherman Antitrust Act [15 U.S.C. §§ 1–7]
5. Firestone Tire & Rubber Co. v. Bruch [489 U.S. 101 (1989)]

Appendix A

Elimination of mental health benefits will go viral and become breaking news. It will be used in algorithms and with hashtags all over social media.

#greedyCEO #choosingmoneyovermentalhealth #nomorecoverage #cuttingcoverage #tugofwarwithcommonsense

#thankyoulawmakers #mentalhealthlegislation #endthestigma #mentalhealthmatters #selfcare #itsokaytonotbeokay #mentalhealthrecovery #mentalhealthawareness #mindfulness #emotionalwellbeing #mentalhealthisasimportantasphysicalhealth

- "Mental Health Benefits Axed: Company CEO Says 'Stress Builds Character"
- "Governor's New Plan: Eliminates Mental Health Benefits, Offers Stress Balls Instead"
- "Cutting Corners: Local Government Slashes Mental Health Benefits, Invests in Spa Days"
- "Employer to Employees: 'Good Luck Out There!' as Mental Health Coverage Disappears"
- "Insurers' Midnight Meeting: 'Let's All Drop Mental Health Coverage, It'll Be Fun!'"
- "Insurers' Plot Uncovered: 'Who Needs Mental Health Coverage Anyway?'"
- "Investors Flee as Company Ditches Mental Health Coverage: 'Oops,' Says CEO"
- "From Coverage Cuts to Closure: The Tale of a Company That Didn't Think It Through"
- "New Law: Mental Health Benefits Now Mandatory, Because Common Sense Finally Prevails"
- "Lawmakers Unite: 'No More Shenanigans, Mental Health Coverage is Here to Stay!'"
- "Emergency Legislation: Mental Health Benefits Saved, Insurers Groan in Defeat"
- "Legislators to Insurers: 'Try Cutting Benefits Now!' as New Law Passes"

ANTITRUST ACT VIOLATIONS IN THE HEADLINES

- "Health Insurers' Secret Club: Busted for Anti-Mental Health Antics"
- "Collusion Confusion: Insurers' Sneaky Pact to Nix Mental Health Benefits"
- "Mental Health Fraud Frenzy: Insurers' Deception Down the Rabbit Hole"
- "Insurers' Mental Health Houdini Act: Now You See It, Now You Don't!"
- "Whistleblower Blows the Lid Off Insurers' Fraudulent Mental Health Shenanigans"
- "Fraud Alert: Insurers' Mental Health Coverage Disappearing Act Exposed"
- "Insurers' Criminal Caper: The Great Mental Health Benefit Heist"
- "Mental Health Coverage Crime Scene: Insurers Under Investigation"
- "Cuffed for Cutting Coverage: Insurers' Mental Health Crime Spree"
- "Wall Street's Wild Ride: Insurers' Mental Health Slip-Up Sends Stocks Tumbling"
- "Insurers' Stock Plunge: The Mental Health Coverage Comedy"
- "Investors' Rollercoaster: Insurers' Mental Health Blunder Tanks Stocks"
- "Lawyers Laughing All the Way to the Bank: Insurers' Legal Fee Fiasco"
- "Cash Cow for Lawyers: Insurers' Mental Health Misstep Leads to Legal Fees Galore"