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The disconnect between policy and practice: evaluating access to behavioral health resources under the Mental Health Parity and Addiction Equity Act

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Thesis

**THE DISCONNECT BETWEEN POLICY AND PRACTICE:
EVALUATING ACCESS TO BEHAVIORAL HEALTH RESOURCES UNDER
THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT**

by

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MOLLY MCGOLDRICK

ABSTRACT

The enactment of the *Mental Health Parity and Addiction Equity Act* (MHPAEA) in 2008 sought to eliminate longstanding discriminatory insurance practices against behavioral health disorders by requiring health insurers of large group plans to apply no more restrictive financial requirements and treatment limitations to mental health and substance use disorder benefits relative to those applied to medical/surgical benefits. Since the parity act went into effect in 2010, the prevalence of mental health conditions has continued to rise while the proportion of those seeking mental health services has remained stagnant. As a result, an increasing trend in the percentage of Americans with a perceived unmet need for behavioral health services has been observed over the past decade. Many of those with an unmet need for services cite an inability to afford the cost of care, no insurance/underinsurance, and/or lack of available behavioral health clinicians as some of the primary reasons for not obtaining wanted care. This suggests a disconnect exists between the policy and practice of parity that warrants further investigation.

Understanding the history of behavioral health coverage and parity in the United States and the current structure of America's health insurance system provides context for why healthcare reform legislations, like the MHPAEA, are necessary. Furthermore, dissecting the provisions and limitations of the MHPAEA and the Affordable Care Act's impact on

behavioral health parity exposes barriers that perpetuate the disconnect between policy and practice. The various barriers that continue to limit access to behavioral health care despite the MHPAEA will be evaluated to better understand why they exist and how they facilitate a persistent unmet need. Mental health in America is a critical medical and public health concern as the prevalence of poor mental health has continued to grow, especially amidst the COVID-19 pandemic. The shortcomings of current legislation and the mental health care delivery system need to be addressed to develop future legislation that can be better equipped to deliver true parity in practice.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
AMI	Any Mental Illness
DHHS	Department of Health and Human Services
DOL	Department of Labor
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders – 4 th Edition
EHB	Essential Health Benefits
ERISA	Employee Retirement Income Security Act
FEHBP	Federal Employees Health Benefits Program
GDP	Gross Domestic Product
HELP	Health, Education, Labor and Pension
HIPPA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organizations
HRSA	Health Resources and Services Administration
IFR	Interim Final Rules
IRO	Independent Review Organization
MBHO	Managed Behavioral Healthcare Organizations
MDE	Major Depressive Episodes
MHPA	Mental Health Parity Act
MHPAEA	Mental Health Parity and Addiction Equity Act
NAMI	National Alliance on Mental Illness
NFCMH	New Freedom Commission on Mental Health

NQTL.....	Non-Quantitative Treatment Limits
NSDUH.....	National Survey on Drug Use and Health
PHSA	Public Health Service Act
QTL.....	Quantitative Treatment Limits
SAMHSA.....	Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
UBH	United Behavioral Health

INTRODUCTION

Mental health disorders are some of the most common health conditions affecting the United States population. According to the 2019 National Survey on Drug Use and Health (NSDUH), approximately 51.5 million (20.6%) of adults over the age of 18 in the United States were found to have any mental illness (AMI) in the past year.¹ Despite the many advances made surrounding mental health care over the past decade, including increased mental health awareness and the implementation of progressive federal policies, millions of Americans with mental health and substance use conditions do not receive behavioral health services.

The passage of the *Mental Health Parity and Addiction Equity Act* (MHPAEA) in 2008 was championed for it represented the integration of behavioral health with general medical care.² Under the MHPAEA, health insurers of large group plans offering mental health and substance use benefits are required to ensure the financial requirements and treatment limitations for behavioral health benefits are “at parity to”, or no more restrictive than, those for medical/surgical benefits.³ The MHPAEA’s parity sentiments were later amplified by the enactment of the *Patient Protections and Affordable Care Act* (ACA) in 2010. The ACA expanded the applicability of the MHPAEA to additional insurance plan types and mandated certain insurance plans provide coverage of Essential Health Benefits (EHB), which included mental health and substance use benefits.³

While an important step in the direction towards equality for behavioral health care, the MHPAEA has its limitations. In the decade since the law was enacted, mental health parity has not yet been fully achieved and there appears to be a disconnect between the policy and the practice of parity. This is evident in that 43.8% of adults experiencing

AMI who perceived an unmet need for mental health services in 2019 did not receive care because they could not afford the cost.¹ The roots of the gap between policy and practice deserves further investigation. To evaluate the incongruences between the policy and practice of parity, the history of behavioral health coverage, operationalization of the MHPAEA by insurance agencies, and the barriers endured by patients seeking mental health services must all be explored to uncover the driving forces behind why so many Americans experiencing behavioral health conditions continue to perceive an unmet need for care.

A Brief History of Mental Health Coverage and Parity

Insurance benefits in the United States for mental health and substance use disorders have historically been less substantial relative to general medical conditions. The many myths and stigmas surrounding mental health for decades created a public misconception that mental disorders were untreatable. This has greatly impacted the way the American insurance-based system treats individuals with mental illness as well as the extent and type of care they receive.

When health insurance plans came to fruition in the 1920s and 1930s, there was little incentive for private insurers to cover mental health services which were already covered through the public sector.^{4,5} At that time, those with mental illness were often considered lost causes and it was standard practice to place mentally ill persons in custodial, state-funded mental institutions.⁶ According to Dr. Steven Sharfstein's 1977 presentation to the American Psychiatric Association, two-thirds of all mental health care costs were paid for through the public sector. Comparatively, less than one-third of all other health care costs were paid for through the public sector.⁷ Today, 44 years later, the

public sector still covers a majority of mental health care costs with Medicaid serving as the largest payer for behavioral health services.⁸

Employers began offering health insurance to employees during World War II when wages were frozen and the workforce was sparse as an incentive since non-taxable, company-provided health insurance was less expensive than individually purchased health insurance.⁴ In the 1950s, some health insurance plans, namely Blue Cross Blue Shield, began including mental health benefits by providing coverage of some inpatient psychiatric care.⁵ Along with the influence of Sigmund Freud and Adolf Meyer, the successful use of psychotherapy in treating soldiers who experienced wartime neuroses during World War II helped to normalize mental health treatment and led to a shift towards psychotherapeutic activism among the general public.⁹ As a result, the post-World War II era saw increased interest in the study of psychiatry, acceptance of psychoanalysis, and sparked the push for deinstitutionalization.¹⁰

The 1950s and 1960s were distinguished by widespread social activism, various rights movements, and the Vietnam War.⁶ Among such social movements was the community mental health movement which called for “deinstitutionalization”. “Deinstitutionalization” describes the replacement of long-term inpatient psychiatric care with outpatient community-based mental health care. The community mental health movement sought to humanize the treatment of individuals with mental disorders, promoted prevention, and advocated for treatment in noninstitutionalized settings.⁵ There were many factors that made the community mental health movement more feasible including the disclosure of inhumane treatment of institutionalized patients, the

introduction of chlorpromazine, increased federal involvement, and a shift in the public's perception on mental health treatment.^{4,6}

The community mental health movement was reinforced by President John F. Kennedy's commitment to improving care for the developmentally disabled and the enactment of the *Community Mental Health Centers Construction Act of 1963* which authorized construction grants for community mental health centers.^{9,11} President Lyndon B. Johnson later increased federal support for the Community Mental Health Act with amendments providing staffing grants in 1965.⁶ The Kennedy-Johnson public health policies were an investment in the public's wellbeing and represented the growing importance of mental health treatment and care.

The goals of the Community Mental Health Act were never fully realized. The rising fiscal demands of the Vietnam War led to the redirection of resources away from community mental health center development and toward the military.⁶ After the Vietnam War, the Presidential Commission on Mental Health, chaired by First Lady Rosalyn Carter, made efforts to revitalize the community mental health centers program with the *Mental Health Systems Act of 1980*. Shortly after its enactment, the act was repealed by President Ronald Reagan as part of his efforts to limit federal involvement and reduce domestic spending.⁶ Consequently, construction of many community mental health centers was never completed, others were left underfunded, and a number of state mental institutions closed. This left numerous deinstitutionalized patients without access to care or means to pay for available care and resulted in increased homelessness, incarceration, and persecution of mentally ill persons.¹²

The community mental health movement and growth of outpatient mental health care had grabbed the attention of the health insurance market. Insurers began to search for ways in which they could profit off the movement and some commercial carriers began offering outpatient mental health benefits in the 1950s.¹³ Many insurers were wary about the financial impacts of maintaining outpatient mental health benefits however. Since treatments had the potential to last for indefinitely long periods of time, cost concerns led many insurers begin placing limits on outpatient mental health care.¹³ Such financial concerns were an unfortunate reality endured by the Actors' Equity Association in the 1950s. A large proportion of the enrolled population sought psychoanalysis soon after the Actors' Equity insurance plan began to include such benefits. After briefly maintaining outpatient mental health benefits, the costs posed too great of a financial strain on the Actors' Equity insurance program and coverage for mental health care again became more limited.^{7,14} While the Actors' Equity experience generated fears of financial strain among insurers, the discussion surrounding the inclusion of mental health benefits within third-party payment plans was revisited in the 1960s.

Quests for mental health parity began in 1961 when President John F. Kennedy asked the U.S. Civil Services Commission to modify the Federal Employees Health Benefits Program (FEHBP), the health insurer for federal employees, to cover mental illnesses the same as it would cover general medical illnesses.⁵ As a result, FEHBP's insurance plans offered parity benefits from 1967 through 1975.¹⁵ FEHBP's parity benefits were nevertheless fleeting. In 1975, FEHBP health plans began allowing more flexibility in benefit design. This led to reduced mental health coverage and the continued diminution of behavioral health benefits.¹⁵

In the 1970s and 1980s, 18 states legislated mandated minimum benefit laws establishing minimum levels of care for mental health treatment.⁵ These mandates were an effort to overcome “adverse selection” and the substantial reductions in mental health care coverage by the private sector during this time.¹⁶ Adverse selection in health insurance is described by Barry et al (2010) as the scenario in which insurance plans that offer better benefits are more likely to be selected for by people who would use such services. This in turn drives up the cost of premiums.⁵ Insurers can then profit from adverse selection by offering minimal benefits to discourage the enrollment of individuals who may opt for plans with more generous insurance coverage.¹⁷ Unfortunately, these state mandated benefit minimums provided incentive for companies to self-insure or look to health maintenance organizations (HMOs), which in many states were exempt from the mandates.¹⁶ Thus, the state mandated minimum benefit laws were less impactful than anticipated and resulted in further segmentation of the insurance market.

During the 1990s, several efforts were made by parity advocates to achieve equal benefits for behavioral health care. The first federal mental health parity legislation was introduced in Congress by the now late Senator Pete Domenici and Former Senator John Danforth in 1992, but no further action was taken.⁵ In 1993, Former President Bill Clinton’s proposed health care reform included the full integration of mental health services at equal benefits as part of the plan’s second phase.⁵ Former President Clinton’s proposed health care reform plan ultimately failed but the pursuits for parity continued at the federal level. In 1995, Senator Domenici worked with the now late Senator Paul Wellstone to introduce a parity legislation they hoped to attach to the *Health Insurance*

Portability and Accountability Act (HIPAA). The Senate voted in favor of parity as an amendment to HIPAA in the spring of 1996, but the amendment was dropped during a Congressional subcommittee meeting negotiations.⁵ Later that year, Senators Domenici and Wellstone introduced a more limited parity bill, the *Mental Health Parity Act of 1996* (MHPA), which was successfully enacted as an amendment to the *Veterans Affairs, Housing and Urban Development* legislation.⁵

The 1996 MHPA prohibits employers who offer mental health benefits from implementing annual and lifetime dollar limits for mental health care that are more restrictive than those for medical/surgical care.¹⁸ MHPA only applied to group health plans with 50 or more employees, did not include substance use services, and did not apply to other mental health benefit limits.⁵ Due to the limited scope of the MHPA, many insurers found ways to place other restrictions on mental health benefits while still complying with the law. A study conducted by the U.S. General Accountability Office in 2000, found that 86 percent of insurance plans that comply with MHPA contain at least one other feature that is more restrictive for mental health coverage relative to medical/surgical coverage within the insurance plan.¹⁹ While this legislation was a step in the right direction, it was clear to parity advocates that a more comprehensive parity law was needed to achieve equal coverage for mental health services.

Bipartisan efforts to implement more comprehensive parity laws began in 1997 and persisted through the early 2000s. Although many efforts stalled in Congress, a great victory for parity advocates came in 1999 when President Clinton instated the most extensive parity effort yet. Set to begin in 2001, Clinton issued a presidential directive requiring comprehensive parity in the FEHBP for both mental health and substance abuse

benefits.¹⁷ In 2002, behavioral health parity gained traction as a bipartisan objective when Republican President George W. Bush advocated for behavioral health parity and formed the president's New Freedom Commission on Mental Health (NFCMH). The commission's goal was to examine the delivery of mental health services in the U.S., in both the public and private sectors, and then provide suggested means for improvements. Included in the commission's final report was a recommendation for mental health parity.²⁰

Motivated by personal and family members' experiences with mental illness, Senator Domenici, Senator Edward Kennedy, Congressman Patrick Kennedy, and Congressman Jim Ramstad continued their legislative pursuits for a more comprehensive parity law. These parity advocates hoped to draft separate bills for passage in both the House and Senate. To help them draft a bill that could be supported by both champions and long-time challengers of parity, Senators Domenici and Kennedy enlisted the help of Senator Michael Enzi in 2005. At the time, Senator Enzi was the chairman of Health, Education, Labor and Pension (HELP) Committee, a committee which had jurisdiction over parity in the Senate.⁵ Senators Enzi and Kennedy invited business and insurance groups to private meetings to negotiate areas of concern. In February of 2007, Senators Domenici, Kennedy, and Enzi introduced the *Mental Health Parity Act of 2007*. The Act was supported by business and insurance groups due to the compromise achieved in the Senate HELP Committee and passed on the Senate floor in September of 2007.⁵

Prior to the 2006 election, then Speaker of the House Dennis Hastert had refused to bring the House parity bill to the floor for consideration, due to objections from some conservative Congress members, despite the legislation having enough cosponsors

needed for passage. With Nancy Pelosi as Speaker and Democrats in control of the House after the 2006 election, Congressmen Kennedy and Ramstad took the opportunity to introduce the *Paul Wellstone Mental Health and Addiction Equity Act* in March of 2007. The bill passed on the House floor in March of 2008, after which the two chambers began negotiations to settle differences between the two legislations. By June, a compromise bill was achieved and efforts made to enact the parity law as a provision to an extended tax break legislation stalled in July. Due to the national party conventions, the parity bill was not revisited by Congress until late-September when it was used as a means to pass a financial bailout package. The House had recently voted to reject a 700-billion-dollar bailout of the financial industry despite bipartisan advocacy for the financial rescue package. Parity advocates were then able persuade 51 House Representatives who cosponsored the parity bill but voted against the bailout to reconsider their vote. In October, with the bailout package amended, the *Mental Health Parity Addiction Equity Act of 2008* was passed into law.⁵

What is the 2008 Mental Health Parity and Addiction Equity Act?

The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* was signed into law by President George W. Bush on October 3, 2008.²¹ The legislation was the result of years of coordinated advocacy from Congresspersons, Senators, champions of behavioral health parity, and advocacy organizations such as Mental Health America and the National Alliance on Mental Illness. Effective for plans renewing on or after January 1, 2010, the MHPAEA sought to establish “parity” by eliminating long-standing and discriminatory differences between health insurance coverage for medical/surgical care and behavioral health care.²² By including substance

abuse benefits in the parity legislation, the law expanded the applicability of the 1996 MHPA's prohibition of special annual and lifetime dollar limits to behavioral health services.⁵ Additionally, the 1996 MHPA and 2008 MHPAEA, collectively referred to as Federal Parity law, together established a set of coverage requirements for behavioral health services that must be equal to those of medical/surgical requirements.³

Under the MHPAEA, insurers who offer behavioral health coverage were required to provide equal benefits for both mental health and substance use services. The "equal benefits" provided by the legislation ensured all financial requirements (i.e. coinsurance, copayments, cost-sharing, and deductibles) and limits on in-patient and outpatient visits for behavioral health services were at parity to those requirements applying to medical/surgical benefits.⁵ This was significant as prior to the enactment of the MHPAEA, coverage for behavioral health care often required a higher level of cost sharing and involved more restrictive quantitative service limits.⁵ Included in the MHPAEA legislation was the protection against more restrictive prior authorization requirements for mental health or substance use services.⁵

When the interim final rules (IFR) were released in February of 2010, several clarifications were made to the provisions included in the MHPAEA. The IFR outlined the prohibition of separately accumulating cumulative financial requirements (i.e. deductibles or out-of-pocket maximums).²¹ The IFR additionally noted parity requirements applied to quantitative treatment limits (QTLs) and nonquantitative treatment limits (NQTLs). NQTLs are defined within the legislation as "limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization)."²¹ Unlike QTLs, it is recognized by

both the Departments of Labor and Human Health Services that NQTLs cannot be evaluated mathematically. The MHPAEA IFR therefore clarified the extent to which insurers subject to the parity law impose NQTLs on behavioral health benefits must be comparable to those imposed on medical/surgical benefits.²¹

Parity and equal benefits however, as they pertain to the legislation, were more conditional as several provisions of the MHPAEA restricted the degree of parity achievable under its law. Perhaps the most notable limiting provision of the MHPAEA stated that employers were not required to provide mental health and substance abuse benefits.⁵ This is termed a “mandated offering parity” approach, where behavioral health coverage is not mandated but, when offered, must be covered at parity with medical/surgical care.³ Additionally, the MHPAEA requirements only applied to employers offering behavioral health benefits with more than fifty employees and to certain plan types (Table 1).³ For example, grandfathered plans, among others, were exempt from complying with the MHPAEA requirements.³ The MHPAEA legislation also did not dictate that specific behavioral health conditions be covered. This meant that services are covered for those behavioral health conditions defined under the terms of a health insurance plan.⁵ These limitations allowed insurers, depending on the plan, to exploit insufficiencies in the underwriting protections of HIPPA by screening patients for mental health history. Insurers could then use information regarding preexisting mental health conditions to “deny coverage, exclude and cap mental health services, increase premiums and cost-sharing, and restrict access to drugs.”²³ Many of these pitfalls of parity were addressed however, with the passage of the Affordable Care Act (ACA) in

2010 and the Final Rules released in November of 2013 elucidated the interplay between the MHPAEA and ACA.

Impact of the Affordable Care Act

The passage of the *Patient Protection and Affordable Care Act* was particularly impactful for those experiencing mental illness who were at greater risk of being uninsured and/or facing greater financial hardships due to mental health expenditures. An estimated 12 million Americans with mental or substance use disorders lacked insurance prior to the enactment of the ACA.² Many of those with mental illness who had insurance endured a lack of parity in insurance benefits for behavioral health treatment which raised the risk of financial strain or inability to afford services due to the higher costs of mental health care.² This changed however when President Barack Obama signed the *Patient Protection and Affordable Care Act* into law on March 23, 2010.²⁴

The ACA established a national coverage mandate, expanded insurance coverage, and instituted ten essential health benefits (EHB) to be covered at a minimum.² Prior to the passage of the ACA, an estimated 43.8 million adults under the age of 65 were uninsured.²⁵ The ACA increased access to insurance coverage by allowing young adults to remain on their parent's health insurance plans until the age of 26, expanding the Medicaid program to all non-Medicare eligible individuals under the age of 65 within 133% of the federal poverty level, and mandating the establishment of state-based exchanges through which individuals and small-businesses can purchase coverage.^{23,24} Following the ACA's coverage expansion efforts, the number of uninsured Americans under the age of 65 dropped to 28.7 million in 2015.²⁵ More recently in 2019, the National Center for Health Statistics found 33.2 million Americans of any age were

uninsured and this number has only increased since the start of the COVID-19 pandemic.²⁶

The ACA effectively extended the reach of federal parity to the Medicaid expansion population, state exchange qualified health plans, as well as to new plans offered through the individual and small-group insurance markets.^{3,27} The ACA also eliminated medical underwriting in the small-group and individual insurance markets which, as a result, prevented plans from denying coverage or exacting cost barriers because of preexisting mental health conditions.²³ Thus, the effective parity legislation of the MHPAEA became more impactful with the enactment of the ACA, a legislation which more prominently integrated behavioral health into federal health policy.

Under the ACA, a minimum set of benefits, known as Essential Health Benefits (EHB), were required to be covered by health plans. Ten service categories for which benefits had to be incorporated as EHB were listed within the ACA; included in these ten service categories were mental health and substance use disorder services.²³ While the ACA did provide a coverage mandate for behavioral health services, it did not necessitate specific mental health and substance use services be included as EHB nor does it require all insurance plans offer EHB (Table 1).³

While the ACA made substantial improvements in reducing the proportion of uninsured Americans and increasing the applicability of federal parity, its reach was not all encompassing. A variety of insurance plans remain partially, or entirely exempt from compliance with the MHPAEA and ACA's EHB (Table 1). Non-managed care Medicaid benchmark and benchmark-equivalent plans are only required to meet parity standards for treatment limitations and financial requirements. Therefore, such plans are only

required to partially comply with the federal parity legislation.³ There also remains an exemption for small employer (less than 50 employees) group health plans, either self-insured or fully insured, nor does federal parity apply to traditional fee-for-service Medicare or Medicaid.³

Table 1. Required Compliance with Federal Parity Law and Coverage of EHB by Insurance Coverage Arrangement. (Adapted from Sarata 2012)

Insurance Coverage Arrangement	Required Compliance with Federal Parity	Required Compliance Established by ACA	Required to Offer EHB
Private Plans			
Large Fully Insured	*		
Large Self-Insured	*		
Small Fully Insured			*
Small Self-Insurance			*
Individual	*	*	*
State Exchange Qualified Health Plans	*	*	*
Public Plans			
Medicare			
Traditional Fee-For-Service Medicaid			
Traditional Medicaid Managed Care Program	*		
Medicaid Fee-For-Service	*	*	*
Benchmark/Benchmark-Equivalent Medicaid Benchmark/Benchmark-Equivalent Managed Care Program	*		*
Children’s Health Insurance Program	*		

Why Is Healthcare Reform Legislation Necessary?

It should be noted that healthcare reform legislations like the MHPAEA and ACA are necessary because of the United States’ current haphazard, profit driven health insurance system. Dominated by the private insurance sector that’s largely supported through employer-sponsored health insurance plans, mixed with federal and state public insurance systems, and supplemented with policies at both the state and federal levels,

health insurance in America is complicated, fundamentally insufficient, and fails to meet the needs of the majority of the population.²⁸

Making health a profit center is unsustainable and counterproductive, as evident by the so-called American Health Care Paradox: poorer health despite immense spending on health care relative to peer countries.²⁹ In 2019, the United States spent 17.7% of its Gross Domestic Product (GDP) on health with an average spending of \$10,966 on health per person. Compared to peer countries whose health expenditures on average represent 11% of their GDP, the United States spends almost twice as much on health per person.^{30,31} A 2019 publication revealed the major reason for the United States' high health expenditures is not a consequence of overuse of health care resources, but rather a result of having higher costs for products and services.²⁸ Having higher costs for health care creates a domino effect that most negatively impacts the people. High health care costs result in higher insurance premiums and more administrative red-tape for coverage approval. This leads insurers and employers to shift more of the financial burden onto enrollees (i.e. higher deductibles, co-pays, and out-of-pocket costs) and increases demand for administrative oversight from medical practices causing more funds to be directed towards administrative costs. Ultimately, the domino effect ends with the middle and upper classes, or those with "good health insurance", having true access to health care. Meanwhile, those less fortunate have limited access, are often behaving as if they are uninsured to avoid medical expenses, and/or must take on medical debt for needed treatment.^{4,28} The way health insurance is currently structured in America results in immensely high costs for health care and delivery without adding any clinical benefits in return and the people are paying the price in poorer health.²⁹

Directly reflective of the insufficiencies inherent to the American health care and insurance systems are the policies and health care reform legislations enacted as amends for such deficiencies. However, because health in America has become a profit-driven over patient-driven market, health care has become a major political issue and it can be difficult to bring about effective change. Investor-owned for-profit insurance companies that predominate the health insurance industry use their ample resources to actively oppose any legislative changes that pose any risk for reducing profits. The MHPAEA was not exempt from such opposing efforts by large for-profit companies. In an attempt to invalidate some of the more significant provisions of the MHPAEA Interim Final Rules (IFR), the managed behavioral healthcare organizations (MBHO) Magellan Health Services, Beacon Health Strategies, and ValueOptions together as the “Coalition for Parity, Inc” filed a lawsuit against the United States Departments of Health and Human Services, Labor, and Treasury.³² The lawsuit unsuccessfully claimed the named federal agencies in charge of implementing the MHPAEA violated the Administrative Procedures Act by issuing the MHPAEA Interim Final Rules without formal notice or first providing a rule for public comment and thus denied their right to participate in the rule-making process.^{5,32} Health care has become such a large economic industry and a major political issue that the voices of private health insurance and health care companies carry substantial weight. As a result, the holes of the American healthcare delivery system are patched little-by-little.

Since American citizens suffer the greatest consequences from the profit-driven health care system, the people frequently have to be their own advocates for change. Often, organized social movements and years of persistent pressure from patients,

consumers, advocates, and/or non-profit organizations are required to generate the congressional support for meaningful change to translate to legislative reform. In fact, the origins of mental health care in America are rooted in social advocacy. For much of the 19th century, mental health care was abysmal and treatment was largely nonexistent. It was common for those with mental illness to be placed in custodial facilities, jailed, assigned to poorhouses, or to live on the streets. This changed in the mid-19th century due to Dorothea Dix and the movement she led in support of public asylums that provide “moral treatment” of mental illness. For three decades Dix travelled from state to state, lobbied legislatures, and called for the state governments’ involvement in mental health care. Dix’s persistent efforts successfully led to the establishment of nearly 30 state-funded institutions.⁶ The need for consistent and unwavering calls for action makes organizations such as Mental Health America and the National Alliance on Mental Illness so essential as they are driving forces for substantial change.

Since private health insurance agencies began their rise to the top of the health insurance market, health has progressively become more of an industry and means for profit than a basic human right. Private insurers act, as any other investor-owned business in a capitalist society would, to maximize profits.⁴ Motivated by financial gain, insurers look to enroll as healthy a population as possible to minimize the cost of premiums. Prior to the ACA, insurers could deny individuals health insurance based on “pre-existing conditions” or other arcane reasons.⁴ This notion of denying patients with greater health concerns insurance coverage for fear of financial loss has greatly contributed to the longstanding discriminatory practices that limit coverage of behavioral health care.

**PREVALENCE OF BEHAVIORAL HEALTH CONDITIONS AND SERVICE
UTILIZATION ACCORDING TO THE 2019 NATIONAL SURVEY ON DRUG
USE AND HEALTH**

About the National Survey on Drug Use and Health

The National Survey on Drug Use and Health (NSDUH) is an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS). NSDUH is a face-to-face interview survey of U.S. civilians aged 12 or older.¹ SAMHSA's NSDUH does not collect data from the populations of those who are institutionalized, active duty military, experiencing homelessness or in shelters.³³ The data yielded by NSDUH provides nationally representative estimates of those experiencing mental health issues or substance abuse disorders in the past year compared to previous years. The survey also provides national estimates of those who received substance use treatment or mental health services and those who perceived an unmet need for behavioral health care. All the data presented in this section has been taken or extrapolated from the 2019 NSDUH results presented by SAMHSA.¹

It is important to note, because NSDUH does not collect data from the populations of those who are institutionalized, active duty military, experiencing homelessness or in shelters, the data is not fully representative of the entire U.S. population. Should the NSDUH data have included information from these populations, it is likely the data would show an increased prevalence of behavioral health issues with reduced rates in access to treatment.³³

Any Mental Illness Among Adults Aged 18 or Older

The prevalence of mental illness among American adults has been on the rise since 2015. In 2019, 51.5 million (or 20.6%) U.S. adults over the age of 18 experienced any mental illness (AMI). AMI is defined by SAMHSA as having any mental, behavioral, or emotional disorder in the past year, excluding substance use disorders and developmental disorders, that meets the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) criteria.³⁴ The percentage of U.S. adults with AMI in 2019 was higher, and statistically significant, than those from each year since 2008 (Figure 1, Table 2).¹

The proportion of adults with AMI has increased since 2008 when 39.8 million (or 17.7%) of adults had AMI in the past year.¹ Since 2008, there has been an average yearly difference of +0.26% of Americans over the age of 18 experiencing AMI. Relative to 2018 when there were 19.1% of U.S. adults with AMI, there was an increase of 1.5% of Americans with past year AMI in 2019. This represents the largest percentage increase between subsequent years to date.

Among U.S. adults between the ages of 18 and 25 in 2019, 9.9 million (or 29.4%) experienced past year AMI. This estimate was higher, and significantly different, than those from each year since 2008. Between 2018 and 2019, there was an increase of 3.1% of adults in this age group who experienced AMI thus, making it the age group with the largest one-year percentage increase in reported AMI.¹

Among U.S. adults between the ages of 29 and 49 in 2019, 25.3 million (or 25.0%) experienced past year AMI. This estimate was higher, and significantly different,

than those from each year since 2008.¹ Between 2018 and 2019, there was an increase of 2.5% of adults in this age group who experienced AMI.

Among U.S. adults over the age of 50 in 2019, 16.3 million (or 14.1%) experienced past year AMI. This estimate was similar to, and not significantly different from, those from each year since 2008. Between 2018 and 2019, there was an increase of 0.1% of adults in this age group who experienced AMI (Figure 1, Table 2).¹

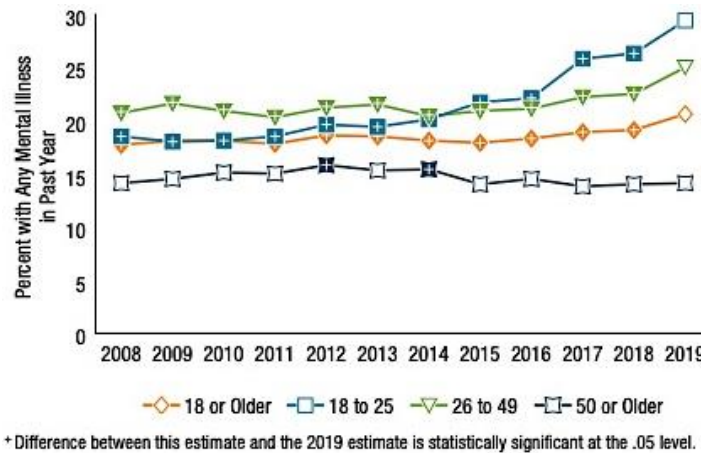


Figure 1. Percentage of U.S. adults over the age of 18 with past year AMI in each year since 2008. (Taken from SAMHSA 2020)

Table 2. Percentage of U.S. adults over the age of 18 with past year AMI in each year since 2008. (Adapted from SAMHSA 2020)¹

Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	17.7*	18.1*	18.1*	17.8*	18.6*	18.5*	18.1*	17.9*	18.3*	18.9*	19.1*	20.6
18 to 25	18.5*	18.0*	18.1*	18.5*	19.6*	19.4*	20.1*	21.7*	22.1*	25.8*	26.3*	29.4
26 to 49	20.7*	21.6*	20.9*	20.3*	21.2*	21.5*	20.4*	20.9*	21.1*	22.2*	22.5*	25.0
50 or Older	14.1	14.5	15.1	15.0	15.8*	15.3	15.4*	14.0	14.5	13.8	14.0	14.1

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

This data demonstrates a statistically significant increase in the percentage of adults aged 18 or older experiencing AMI in every year since 2008. Adults aged 18 to 25 were not only the age group with the highest percentage of AMI in the past year, this demographic also showed the most substantial increase (11.4%) in reported AMI in the past decade. In all age groups, except for those 50 years or older, the estimated

percentages with AMI in 2019 were higher than the estimates in each year since 2008. Similar trends were observed among U.S. adults with serious mental illness.

Serious Mental Illness Among Adults Aged 18 or Older

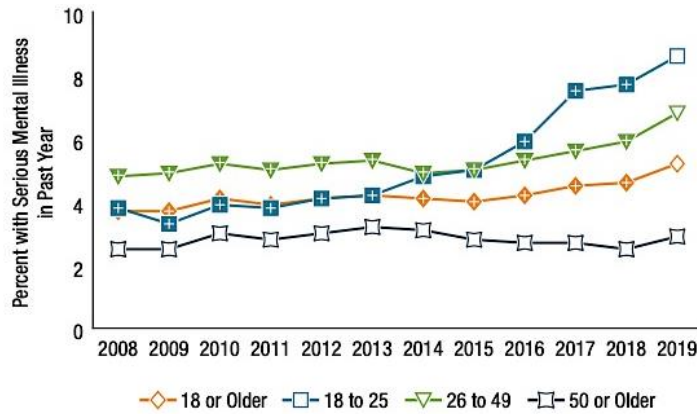
In 2019, 13.1 million (or 5.2%) U.S. adults over the age of 18 experienced a serious mental illness (SMI). SAMHSA classified individuals with AMI as having a SMI if “they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities”.¹ The percentage of U.S. adults with SMI in 2019 was significantly higher than those from each year since 2008 (Figure 2, Table 3).¹

The proportion of adults with a SMI has increased since 2008 when 8.3 million (or 3.7%) adults had a past year SMI. Relative to 2018 when there were 4.6% of U.S. adults with SMI, there was an increase of 0.6% of Americans with past year SMI in 2019. This represents the largest percentage increase between subsequent years since 2008.¹

Among U.S. adults between the ages of 18 and 25 in 2019, 2.9 million (or 8.6%) experienced past year SMI. This estimate was higher, and significantly different, than those from each year since 2008. Between 2018 and 2019, there was an increase of 0.9% of adults in this age group who experienced SMI. This age group saw the same percentage increase in reported SMI between 2018 and 2019 as that for adults between 26 to 49 years old.¹

Among U.S. adults between the ages of 29 and 49 in 2019, 6.8 million (or 6.8%) experienced past year SMI. This estimate was higher, and significantly different, than those from each year since 2008. Between 2018 and 2019, there was an increase of 0.9% of adults in this age group who experienced SMI.¹

Among U.S. adults over the age of 50 in 2019, 3.4 million (or 2.9%) experienced a SMI in the past year. This estimate was similar to, and not significantly different from, those from each year since 2008. Between 2018 and 2019, there was an increase of 0.1% of adults in this age group who experienced SMI (Figure 2, Table 3).¹



* Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Figure 2. Percentage of U.S. adults over the age of 18 with past year SMI in each year since 2008. (Taken from SAMHSA 2020)

Table 3. Percentage of U.S. adults over the age of 18 with past year SMI in each year since 2008. (Adapted from SAMHSA 2020)

Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	3.7*	3.7*	4.1*	3.9*	4.1*	4.2*	4.1*	4.0*	4.2*	4.5*	4.6*	5.2
18 to 25	3.8*	3.3*	3.9*	3.8*	4.1*	4.2*	5.8*	5.0*	5.9*	7.5*	7.7*	8.6
26 to 49	4.8*	4.9*	5.2*	5.0*	5.2*	5.3*	4.9*	5.0*	5.3*	5.6*	5.9*	6.8
50 or Older	2.5	2.5	3.0	2.8	3.0	3.2	3.1	2.8	2.7	2.7	2.5	2.9

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

Similar to the trends observed in adults with AMI, this data demonstrates a statistically significant increase in the percentage of adults aged 18 or older experiencing SMI in every year since 2008. Adults aged 18 to 25 were not only the age group with the highest percentage of SMI in the past year, this age group also showed the most substantial increase (5.3%) in reported SMI in the past decade. In all age groups, except for those 50 years or older, the estimated percentages of adults with SMI in 2019 were higher than the estimates in each year since 2008.¹ The persistent increase in adults

experiencing AMI or SMI demonstrates an increased need for mental health services and prevention. For an increase in service utilization to be possible, there is an urgent need for true mental health parity.

Major Depressive Episode Among Adults Aged 18 or Older

In 2019, 19.4 million (or 7.8%) U.S. adults over the age of 18 experienced a major depressive episode (MDE) in the past year. The proportion of adults experiencing MDE has increased since 2005 when 14.2 million (or 6.6%) adults had a MDE in the past year (Figure 3, Table 4).¹ An individual is classified by SAMHSA as having had a MDE if they experienced the following in the past year:

- (1) Feeling depressed, or having little interest in daily activities, for the majority of each day for two weeks or longer.
- (2) Having problems with concentration, eating, energy, and/or sleeping.
- (3) Having recurrent thoughts of death or suicidal ideation.

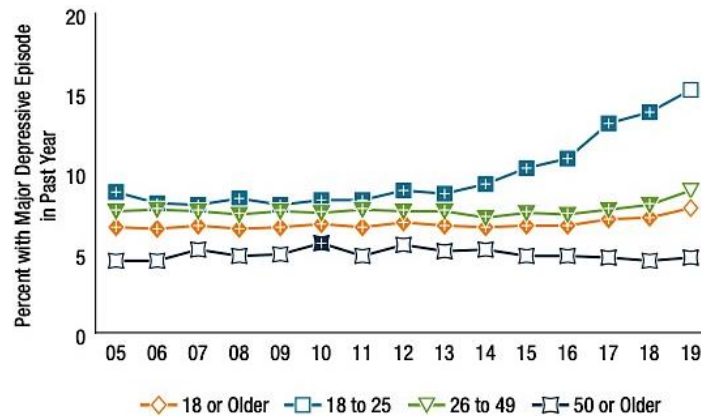
The percentage of U.S. adults with MDE in 2019 was statistically higher than those from each year since 2005.¹ Relative to 2018 when 7.2% of U.S. adults experienced MDE, there was an increase of 0.6% of American adults with past year MDE in 2019. This represents the largest percentage increase between subsequent years since 2005.

Among U.S. adults between the ages of 18 and 25 in 2019, 5 million (or 15.2%) experienced MDE in the past year. This estimate was higher, and significantly different, than those from each year since 2005. In 2005, 2.8 million (or 8.8%) of adults had MDE in the past year. Between 2005 and 2019, there was an increase of 6.6% of adults in this age group with past year MDE. Between 2018 and 2019, there was an increase of 1.4% of adults in this age group who experienced MDE. This age group saw the largest

percentage increase in reported MDE since 2005 and largest yearly percentage increase between 2018 and 2019.¹

Among U.S. adults between the ages of 29 and 49 in 2019, 8.9 million (or 8.9%) experienced past year MDE. This estimate was higher, and significantly different, than those from each year since 2005. In 2005, 7.5 million (or 7.6%) were reported to have had a past year MDE. Between 2018 and 2019, there was an increase of 0.9% of adults in this age group who experienced MDE.¹

Among U.S. adults over the age of 50 in 2019, 5.4 million (or 4.7%) experienced MDE in the past year. This estimate has remained stable and is similar to the estimates from each year since 2005 (Figure 3, Table 4).¹



* Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Figure 3. Percentage of U.S. adults over the age of 18 who experienced MDE in each year since 2005. (Taken from SAMHSA 2020)

Table 4. Percentage of U.S. adults over the age of 18 who experienced MDE in each year since 2005. (Adapted from SAMHSA 2020)

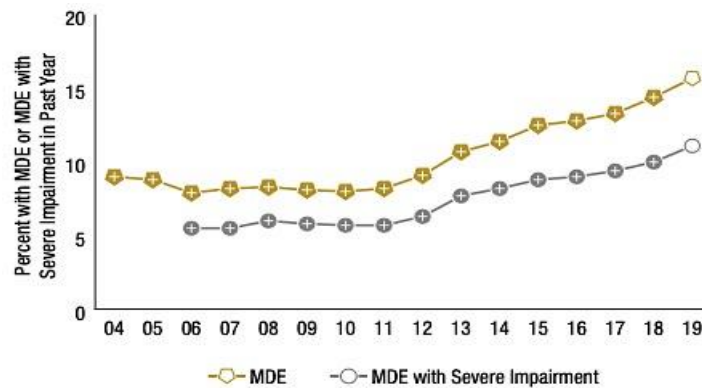
Age	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
18 or Older	6.6*	6.5*	6.7*	6.5*	6.6*	6.8*	6.6*	6.9*	6.7*	6.6*	6.7*	6.7*	7.1*	7.2*	7.8
18 to 25	8.8*	8.1*	8.0*	8.4*	8.0*	8.3*	8.3*	8.9*	8.7*	9.3*	10.3*	10.9*	13.1*	13.8*	15.2
26 to 49	7.6*	7.7*	7.6*	7.4*	7.6*	7.5*	7.7*	7.6*	7.6*	7.2*	7.5*	7.4*	7.7*	8.0*	8.9
50 or Older	4.5	4.5	5.2	4.8	4.9	5.6*	4.8	5.5	5.1	5.2	4.8	4.8	4.7	4.5	4.7

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

Major Depressive Episode Among Adolescents Aged 12 to 18 in 2019

Adolescents were classified by SAMHSA as having had a MDE using the same indicators previously listed for adults. However, some of the questions regarding depression and MDE posed to adolescents differed in how they were worded relative to those posed to adults. Therefore, as stated by SAMHSA, the MDE estimates for adolescents cannot be directly compared to those of adults and are thus considered separate.¹

In 2019, 3.8 million (or 15.7%) adolescents between the ages of 12 and 17 experienced a MDE in the past year and 2.7 million (or 11.1%) experienced MDE with severe impairment. The percentage of adolescents with MDE and MDE with severe impairment in 2019 were higher, and significantly different, than those from each year since 2004 and 2006 respectively.¹ The proportion of American youths experiencing MDE has increased since 2004 when 2.2 million (or 9.0%) adolescents reported a past year MDE. Similarly, the estimates for those having experienced a past year MDE with severe impairment have increased since 2006 when 1.4 million (or 5.5%) had an MDE with severe impairment (Figure 4, Table 5).¹



* Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Figure 4. Percentage of adolescents aged 12 to 17 with past year MDE and MDE with severe impairment in each year since 2004. (Taken from SAMHSA 2020)

Table 5. Percentage of adolescents aged 12 to 17 with past year MDE and MDE with severe impairment in each year since 2004. (Adapted from SAMHSA 2020)

MDE Status	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
MDE	9.0*	8.8*	7.9*	8.2*	8.3*	8.1*	8.0*	8.2*	9.1*	10.7*	11.4*	12.5*	12.8*	13.3*	14.4*	15.7
MDE with Severe Impairment	N/A	N/A	5.5*	5.5*	6.0*	5.8*	5.7*	5.7*	6.3*	7.7*	8.2*	8.8*	9.0*	9.4*	10.0*	11.1

N/A = Data not available

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

Suicidal Ideations and Behaviors Among Adults Aged 18 or Older in 2019

Suicide remains an important public health concern as national suicide rates have been persistently increasing since 1996.¹ One Centers for Disease Control and Prevention study found suicide rates had increased by more than 30% in 25 states between 1996 and 2016.³⁵ In 2019, 12 million (or 4.8% of) U.S. adults over the age of 18 had seriously considered suicide. This estimate was higher, and significantly different, than those from each year since 2008. Of those who considered suicide, 3.5 million (or 1.4%) made a suicide plan, 1.4 million (or 0.6%) made a nonfatal attempt, and 217,000 (or 0.1%) attempted suicide without a plan in the past year (Figure 5)¹.

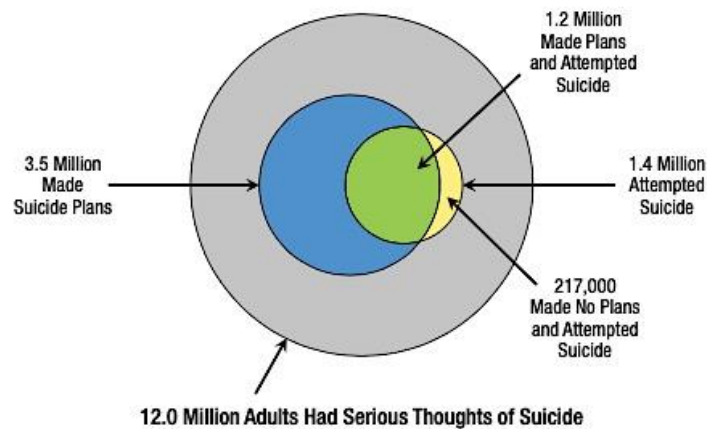


Figure 5. Adults aged 18 or older with serious thoughts of suicide, suicide plans, and/or suicide attempts in 2019. (Taken from SAMHSA 2020)

The national trends of increasing prevalence of MDE among both adults and adolescents are consistent with the observed increases in suicide attempts and deaths by

suicide among both age demographics over the past 15 years.¹ This persistent increase in the prevalence of MDE and rise in suicide rates since 2005 underscores the importance and necessity of mental health care and suicide prevention.

Mental Health Service Utilization Among Adults

Adults over the age of 18 were classified by SAMHSA as having used mental health services in the past year if they received any counseling, treatment, and/or took prescription medication for emotional or mental health condition(s). This excluded any treatment or services used in relation to substance use¹.

Among the 51.5 million adults with AMI in 2019, 44.8% received mental health services in the past year. This 2019 percentage estimate, while higher than those from 2008 to 2012, was similar to the percentages from most years between 2013 and 2018.¹ This data suggests a slight increase in mental health service utilization after the enactment of the MHPAEA and ACA. Since 2013 however, there has not been a statistically significant change in the proportion of adults with AMI receiving mental health services despite a persistent increase in the prevalence of AMI among adults.

Among the 13.1 million adults with past year SMI, 65.5% received mental health services in 2019. This 2019 percentage estimate was similar to those from each year since 2008.¹ The lack of significant change in the proportion of adults with SMI receiving mental health services since 2008, despite the persistent increase in prevalence of SMI among adults, suggests there has not been an increase in utilization or access to mental health care since the enactment of either MHPAEA or ACA. Similar trends were also observed within each age demographic of adults with past year SMI in which there has

been no significant change in the percentage of those receiving treatment in most years since 2008 (Figure 6, Table 6)¹.

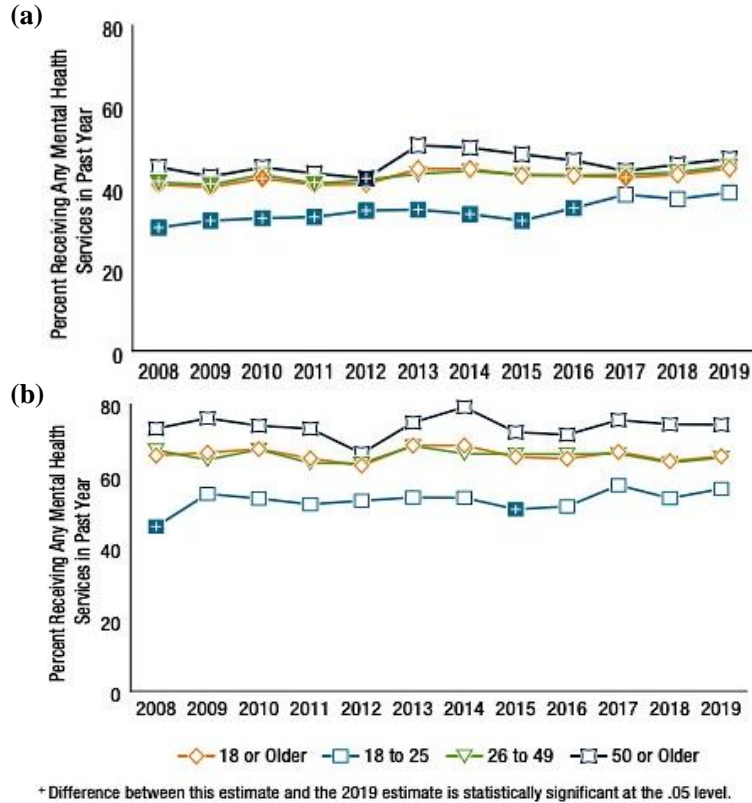


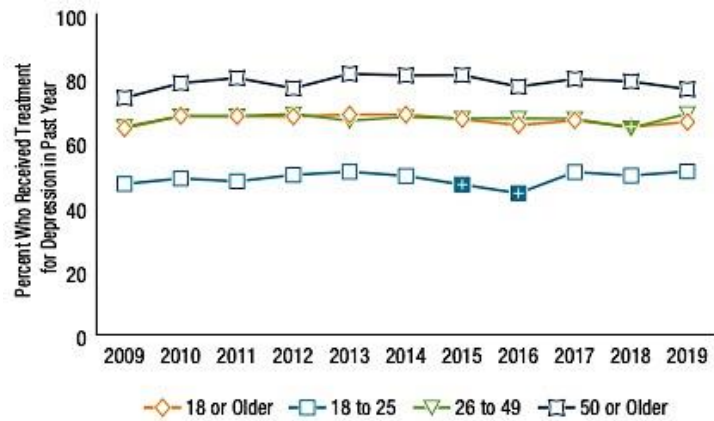
Figure 6. Mental health service utilization among adults with AMI (a) and SMI (b) in each year since 2008. (Taken from SAMHSA 2020)

Table 6. Mental health service utilization among adults with AMI and SMI in each year since 2008. (Adapted from SAMHSA 2019)

Mental Health Service Utilization Among Adults with AMI												
Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	40.9*	40.2*	42.4*	40.8*	41.0*	44.7	44.7	43.1	43.1	42.6*	43.3	44.8
18 to 25	30.3*	32.0*	32.6*	32.9*	34.5*	34.7*	33.6*	32.0*	35.1*	38.4	37.3	38.9
26 to 49	41.4*	40.8*	43.3	41.1*	42.0*	43.5	44.2	43.3	43.1	43.3	43.9	43.4
50 or Older	45.2	42.8	45.1	43.6	42.4*	50.5	49.9	48.3	46.8	44.2	45.8	47.2
Mental Health Service Utilization Among Adults with SMI												
Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	65.7	66.5	67.5	64.9	62.9	68.5	68.5	65.3	64.8	66.7	64.1	65.5
18 to 25	45.9*	55.0	53.7	52.1	53.1	54.0	53.9	50.7*	51.5	57.4	53.8	56.4
26 to 49	67.2	64.5	67.4	63.6	63.5	68.4	66.2	66.1	66.1	66.2	63.7	65.1
50 or Older	73.2	76.1	74.0	73.2	66.3	74.9	79.2	72.2	71.5	75.6	74.4	74.3

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

Adults identified to have experienced MDE in the past year were specifically asked if they had received any treatment for their depression. Respondents were classified by SAMHSA as having received treatment for depression if they saw or spoke to a professional (health professional or other professional) and/or if they took prescription medication for depression. In 2019, 66.3% of the 19.4 million adults with MDE received treatment for depression. Of the 13.1 million adults who had MDE with severe impairment, 72.2% received treatment. Both percentage estimates of those receiving treatment for MDE and treatment for MDE with severe impairment are similar to those reported in each year since 2009.¹ Despite persistently increasing rates of MDE among adults since 2008, the percentage receiving treatment has not increased proportionally. This suggests there has not been an increase in access or utilization of mental health services since the enactment of federal parity laws and the ACA. The same trends of insignificant change in the proportion receiving treatment for depression in most years since 2009 was observed within each age group of adults with past year MDE (Figure 7, Table 7). Only one minor exception to this trend was observed. Among the 8.9 million adults aged 26 to 49 with MDE in 2019, the percentage who received treatment in the past year (68.9%) was higher than that from 2018, but was otherwise similar to, and not significantly different from, those percentages in each year between 2009 and 2017 (Figure 7, Table 7).¹



* Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Figure 7. Percentage of adults with past year MDE who received treatment for depression in each year since 2008. (Taken from SAMHSA 2020)

Table 7. Percentage of adults with past year MDE who received treatment for depression in each year since 2008. (Adapted from SAMHSA 2020)

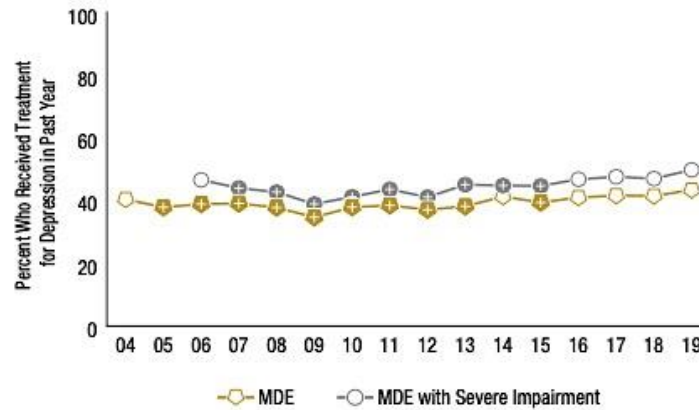
Age	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	64.3	68.2	68.1	68.0	68.6	68.6	67.2	65.3	66.8	64.8	66.3
18 to 25	47.0	48.7	47.8	49.8	50.8	49.5	46.8*	44.1*	50.7	49.6	50.9
26 to 49	64.8	68.1	68.1	68.8	66.7	67.9	67.4	67.4	67.3	64.4*	68.9
50 or Older	73.8	78.4	80.0	76.8	81.3	80.8	80.9	77.3	79.7	78.9	76.5

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

Mental Health Service Utilization Among Adolescents

Adolescents identified to have experienced MDE in the past year were specifically asked if they had received any treatment for their depression. Similar to adults, adolescent respondents were classified by SAMHSA as having received treatment for depression if they saw or spoke to a health professional and/or if they took prescription medication for depression. In 2019, 43.3% of the 3.8 million adolescents with past year MDE received treatment for their depression. Among the 2.7 million adolescents who had past year MDE with severe impairment, 49.7% received treatment. Both of these percentage estimates were higher than those reported in most years between 2005 and 2015 but similar to the percentages from 2016 to 2018 (Figure 8, Table 8).¹

This demonstrates no increase in treatment among adolescents with MDE despite overserved continued increase in proportion of adolescents with MDE after the enactment of the MHPAEA.



* Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

Figure 8. Percentage of adolescents with past year MDE and MDE with severe impairment who received treatment for depression in each year since 2004. (Taken from SAMHSA 2020)

Table 8. Percentage of adolescents with past year MDE and MDE with severe impairment who received treatment for depression in each year since 2004. (Adapted from SAMHSA 2020)

MDE Status	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
MDE	40.3	37.8*	38.8*	39.0*	37.7*	34.6*	37.8*	38.4*	37.0*	38.1*	41.2	39.3*	40.9	41.5	41.4	43.3
MDE with Severe Impairment	N/A	N/A	46.5	43.9*	42.6*	38.8*	41.1*	43.5*	41.0*	45.0*	44.7*	44.6*	46.7	47.5	46.9	49.7

N/A = Data not available

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

Perceived Unmet Need Among Adults

Adults over the age of 18 reported to have AMI or SMI were asked if they had perceived an unmet need for mental health services at any time in the past year and if so, what was the reason for not receiving services. What constitutes as “perceived unmet need” according to SAMHSA is if an individual saw a need for mental health counseling or treatment at any time in the past year but did not receive such services. This measure

was considered for all adults with AMI or SMI regardless if they received mental health care before or after perceiving an unmet need.

Of the 51.5 million adults with AMI in 2019, 26.0% (or 13.3 million) perceived an unmet need. This percentage was statistically higher than the estimates in most years from 2008 to 2018 (Figure 9, Table 9).¹ Among the 13.3 million adults with past year AMI who perceived an unmet need, 43.8% did not receive any mental health services in 2019 (Figure 9, Table 9). As for the 13.1 million adults with SMI in 2019, 47.7% perceived an unmet need for mental health care. This 2019 estimate was higher than those from each year since 2008 (Figure 9, Table 9). Of those adults with past year SMI and a perceived unmet need, 32.8% did not receive mental health services.¹ This data provides evidence that despite the establishment of federal parity and enactment of the ACA, there has been an increase in the perceived unmet need for mental health services among adults with AMI and SMI.

The young adult demographic had the largest perceived unmet need for mental health services. This was made evident in that 40.7% of the 9.9 million adults aged 18 to 25 with AMI reported an inability to receive mental health care at some point in 2019. Additionally, 62.5% of the 2.9 million young adults with past year SMI saw an unmet need for services in 2019. These proportions of young adults with AMI and SMI experiencing an unmet need in 2019 were higher than those from nearly each year between 2008 and 2018. Among those young adults with past year AMI and a perceived unmet need, 53.1% did not receive any mental health services in 2019. Of those young

adults with SMI and perceived unmet need, 43.2% did not receive any mental health care in 2019 (Figure 9, Table 9).

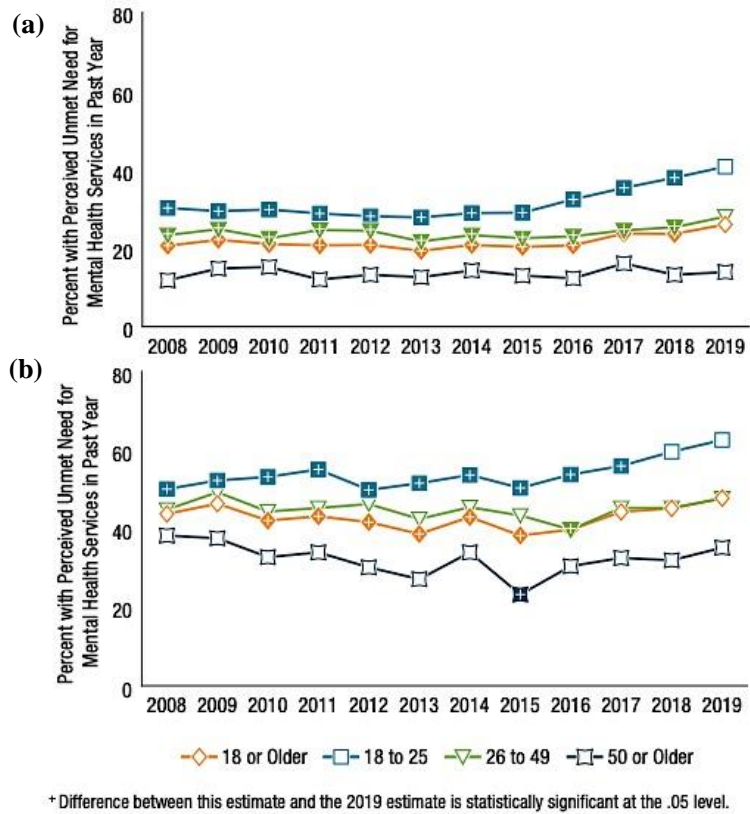


Figure 9. Percentage of U.S. adults age 18 or older with AMI (a) and SMI (b) who perceived an unmet need for mental health services by year from 2008 to 2019. (Taken from SAMHSA 2020)

Table 9. Percentage of U.S. adults age 18 or older with AMI or SMI who perceived an unmet need for mental health services by year from 2008 to 2019. (Adapted from SAMHSA 2020)

Perceived Unmet Need for Mental Health Services Among Adults with AMI												
Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	20.6*	22.1*	21.0*	20.7*	20.8*	19.3*	20.8*	20.3*	20.7*	23.7*	23.6*	26.0
18 to 25	30.2*	29.4*	29.8*	28.8*	28.1*	27.8*	28.9*	29.0*	32.4*	35.3*	37.9*	40.7
26 to 49	23.3*	24.8*	22.5*	24.6*	24.4*	21.7*	23.3*	22.5*	23.0*	24.5*	25.3*	28.0
50 or Older	11.8	14.8	15.2	12.0	13.2	12.6	14.3	13.0	12.3	16.1	13.2	13.9
Perceived Unmet Need for Mental Health Services Among Adults with SMI												
Age	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
18 or Older	43.7	46.3	42.0*	43.1*	41.6*	38.6*	42.9*	38.2*	39.7*	44.2	45.1	47.7
18 to 25	50.0*	52.2*	53.1*	55.0*	49.8*	51.5*	53.6*	50.3*	53.7*	55.9*	59.5	62.5
26 to 49	44.8	49.2	44.3	45.2	46.2	42.4	45.4	43.3	39.7*	45.2	45.2	47.6
50 or Older	38.2	37.5	32.7	33.9	30.1	27.1	33.9	23.2*	30.4	32.5	31.9	35.1

* Difference between this estimate and the 2019 estimate is statistically significant at the 0.05 level

Among adults with AMI or SMI who saw an unmet need for mental health services and did not receive behavioral health care in 2019, the most common reason for not receiving services was their inability to afford the cost of care. Other common reasons for not receiving services are listed in Table 10.

Table 10. Common reasons for not receiving mental health services among adults with mental illness and a perceived unmet need for treatment. (Adapted from SAMHSA 2020)

Reason for Not Receiving Mental Health Services	Percent of Adults with AMI	Percent of Adults with SMI
Could Not Afford Cost of Care	43.9	51.8
Did Not Know Where to Go for Care	33.1	36.8
Believed Problem Could be Managed Without Treatment	30.5	27.3
Fear of Needing to Take Medications or Being Committed to Psychiatric Hospital	n/a*	23.4

*n/a - Indicates there was no available data for this parameter

BARRIERS TO BEHAVIORAL HEALTH CARE

Although both the MHPAEA and ACA have been viewed by behavioral health advocates as substantial legislative successes, the number of adults with AMI reporting an unmet need for behavioral health services has not declined since 2011.³³ Several studies and reports have identified several barriers which continue to hinder a patients' ability to obtain quality behavioral health care. Such barriers were identified by Mental Health America as the following: (1) no insurance or limited coverage of services, (2) limited availability of psychiatrists and an overall undersized mental health workforce, (3) deficiency in available treatment types, (4) lack of coordination between primary care and behavioral health systems, and/or (5) insufficient finances to cover costs.³³ These barriers remain due to insufficiencies in the behavioral health care delivery system including comprehensive insurance coverage, compliance with MHPAEA and ACA, private enforcement process, and access. To achieve true parity, we must first investigate these areas of insufficiencies as a means for identifying ways to improve behavioral health coverage, access, and eradicate the persistent unmet need.

Lack of Comprehensive Coverage Despite Increased Insurance Coverage After ACA

Since the enactment of the ACA in 2010, there has been a decrease in the number of uninsured Americans from 48 million to 33.2 million Americans as of 2019.²⁶ In addition to the NSDUH and Mental Health America identifying inability to afford cost of care and no insurance or underinsurance as primary barriers to accessing behavioral health, a 2018 study found 42% of Americans perceived cost and poor insurance as the primary barriers to behavioral health care. Additionally, 25% of U.S. population had to

choose between receiving mental health services and paying for daily necessities.^{1,33,36} Evidently, inadequate coverage of behavioral health services persists despite federal parity laws and the increased percentage of insured Americans.^{1,33} A study conducted by the Commonwealth Fund found 44 million U.S. adults were underinsured in 2018. In 2010 when the ACA was enacted, 29 million adults were underinsured meaning, the proportion of underinsured Americans has increased since 2010 with the largest increase observed among those insured through employer health plans.³⁷ This shows that an increase in insured Americans does not translate to an increase in sufficient coverage. Subsequently due to inadequate coverage, consumers have faced cost-related barriers to care such as higher out-of-pocket costs and deductibles.^{37,38}

In addition to cost-related barriers, individuals have been denied coverage for needed treatment due to limiting stipulations within the terms of health insurance plans or use of more restrictive NQTLs. NQTLs include coverage exclusions, prior authorization, step therapy requirements, and utilization reviews.³⁹ Coverage exclusions are policy provisions which outline certain treatments and services not covered by insurance.³⁹ Prior authorization is the requirement for insurance approval in advance of coverage. Step therapy requirements describe a process in which insurers require patient to first try and fail lower costing therapies before obtaining coverage for more costlier therapies.³⁹ Utilization reviews describe the process by which insurers determine coverage approval on a treatment-by-treatment basis based on “medical necessity”.³⁹ Denials based on more restrictive medical necessity determinations have been at the center of many patient litigations against insurers and will be discussed in greater detail in a subsequent section.

As long as they are not disproportionately applied to behavioral health benefits, NQTLs are allowable under the ACA and MHPAEA as neither of these laws specify that *all* or even certain behavioral health services be covered. Insurers therefore have the freedom to establish their own definitions, standards, and criteria for utilization review processes and apply NQTLs to behavioral health benefits at their discretion.^{40,41} As a result, substantial variability exists between states and among plans in coverage of behavioral health benefits. Not only do these restrictive standards outline ambiguous criteria beneficiaries must meet to qualify to coverage, they often make it difficult for patients to obtain coverage for necessary treatments, especially in a timely manner.

Insufficient Enforcement and Noncompliance

Another contributing factor to the persistent perceived unmet need for behavioral health services has been a deficient enforcement of federal parity. The responsibilities for ensuring compliance with federal parity are divided among multiple federal and state governmental agencies. At the federal level this includes the DHHS, Department of the Treasury, Department of Labor (DOL), and the Internal Revenue Service among others.⁴⁰ To create more coordinated oversight of MHPAEA, President Barack Obama established an interagency parity task force in March of 2016 to promote best practices and compliance.⁴⁰ At the states level, those which have incorporated Federal Parity into state law and/or implemented parity laws of their own have established independent enforcement measures, especially those for ensuring parity level NQTLs.⁴² This multi-agency and interagency enforcement creates an imperfect patchwork of oversight and its shortcomings have led to issues of noncompliance. According to a 2015 Johns Hopkins

University study, 25% of health insurance plans offered through exchanges failed to comply with federal parity requirements.⁴¹

Compliance concerns have especially centered on NQTLs which are more vulnerable to violations due to the difficulties associated with monitoring these restrictive standards. An investigation performed by the Attorney General's Office of New York State identified several insurance plans, in direct noncompliance with federal parity, had been employing more restrictive NQTLs, namely utilization review processes, for behavioral health benefits than for medical/surgical benefits. Despite the disclosure rights clarified in the MHPAEA final rules noting insurers are required to automatically provide reasons for denials, reimbursements, or payments, such documentation is often ambiguous and lacks transparency. This ambiguity was recognized in the New York State Attorney General's investigation which also found the basis for denied coverage of mental health and substance use services were more likely to be insufficiently explained compared to denial letters for medical/surgical services.^{40,40,43} Another indication of ongoing NQTL compliance issues is that the Employee Benefits Security Administration's, an agency within the DOL that shoulders some of the MHPAEA enforcement responsibility, determined 55% of MHPAEA violations pertained to NQTLs in 2018.⁴⁴ Such findings validate the ongoing concerns surrounding compliance with MHPAEA's requirements for NQTLs.

The challenges of assessing NQTLs applied to behavioral health care at parity to those for medical/surgical care were recognized in the MHPAEA Final Rules. The final regulations discuss both the inability to evaluate NQTLs mathematically and the challenges in determining whether a plan complies with NQTL parity provisions without

extensive documentation comparing the processes, strategies, and standards of applying these managed care processes to behavioral health benefits versus medical/surgical benefits.²¹ This comparative approach is problematic since trying to compare such NQTL procedures for behavioral health and general medical coverage is in essence comparing day and night. Furthermore, these difficulties associated with monitoring NQTL parity compliance also act as obstacles to beneficiaries appealing denied claims based on NQTL utilization review processes.

Appealing a Denied Claim

A 2015 survey conducted by the National Alliance on Mental Illness (NAMI) found mental health claims are twice as likely to be denied as medical/surgical claims. Additionally, the study reported 29% of respondents had been denied coverage of mental health care based on medical necessity and 18% of respondents had been denied substance use care. Comparatively, 14% reported having been denied general medical care.⁴³ Due to the complications associated with challenging MHPAEA policies, many litigators have instead brought actions against insurers under the Employee Retirement Income Security Act (ERISA), a federal statute that regulates employee benefits.⁴⁵ However, not all individuals impacted by inappropriate behavioral health coverage denials are afforded the right to challenge claims in court. Only individuals with ERISA-covered plans, including employer-sponsored insurance which offer behavioral health benefits, are granted the right to privately enforce parity and due process remedies under ERISA.^{42,45} Those insured through ERISA-exempt plans, including non-federal government employees and privately insured individuals, cannot invoke such private parity enforcement and must instead explore indirect and possibly less effective legal

alternatives to appeal a denied claim. This is because the ACA and MHPAEA are applicable through the Public Health Service Act (PHSA), a legislation that does not explicitly grant private enforcement rights.⁴²

Of the civil actions claimants have brought against insurers, many have particularly centered on access to residential treatment facilities and overly stringent medical necessity determinations.⁴⁵ Early stages of appeals often feature a partial internal review process associated with low win rates.³⁹ In an effort to avoid litigation, the ACA conferred beneficiaries of non-grandfathered plans subject to PHSA or ERISA the ability to challenge denied behavioral health claims based on medical necessity determinations through independent external reviews. Furthermore, the operationalization of the ACA placed the responsibility of overseeing the application of NQTLs to behavioral health benefits in compliance with Federal Parity in the hands of independent review organizations (IROs).⁴² For those appealing denied claims based on unlawful NQTLs with the resources and persistence to pursue appeal, later stages of appeal involve an external review by an IRO. Although external review processes have been more successful in overturning adverse insurer determinations, they are not free of fault. Many IROs are contracted with managed behavioral healthcare organizations and state insurance departments. This blatant conflict of interest yields diminished incentives for IROs to overturn denials and consequently, parity or due process violations are often overlooked. This is especially apparent in cases for fully insured and self-funded plans in which the financial burdens of reversal fall entirely on the IRO's hiring insurer, not an employer. Additionally, the external review process for both of these plans does not necessitate transparency concerning medical necessity criteria and regulations used by

IROs. It is therefore possible for a claimants efforts to reverse denials for behavioral health coverage based on medical necessity to be invalidated by the IRO's final ruling.⁴²

For claimants under ERISA-covered plans granted the protection to exercise private enforcement, the process for challenging a denied coverage claim inherently lends itself in favor of “better-connected, better-educated, and wealthier [claimants] with cultural capital and trust in the legal system necessary to identify and take action to rectify wrongdoing.”³⁹ This, in combination with the other aforementioned barriers to the appeals process, contributes to the significantly low rates of appeals for denied claims. In 2019, consumers insured through ACA marketplace plans appealed 0.2% of denied claims and 60% of these appeals upheld the insurers original decision during the internal review process. Moreover, fewer than 1 in 20,000 denied claims made it to external review.⁴⁶

Should a claimant under an ERISA-covered plan successfully appeal a denied claim, ERISA prohibits punitive damages for inappropriate benefit denials.²⁰ As described by Meiram Bendat, an attorney whose legal practice is dedicated to challenging mental health coverage denials, this means beneficiaries cannot sue for more than “owed benefits, injunctive relief, and at best, attorney fees – assuming that individual litigants can even find counsel to represent them”.⁴² This lack of monetary punishment for insurers coupled with the fact that beneficiaries rarely appeal denied claims perpetuates the discriminatory use of more restrictive NQTLs for denying behavioral health claims and provides an incentive for insurers to continue violating the MHPAEA and ACA.

In a recent class action law suit asserted under ERISA against United Behavioral Health (UBH), *Wit v. UBH*, Judge Joseph Spero held that UBH, the largest health insurer

in the U.S., had breached its fiduciary duties through deliberately failing to conform to accepted standards of treatment.⁴⁷ The Court also found evidence within internal UBH documents which “indicated financial considerations significantly influenced the company’s development of overly restrictive guidelines and criteria opposed to having been guided by the needs of its insured.⁴⁵ During his review of published guidelines, Judge Spero identified eight principles that constituted accepted standards of care which have since been endorsed by the Medical Director Institute of the National Council for Behavioral Health with the addition of greater transparency and particular emphasis on co-occurring conditions (Table 11).⁴⁵ These standards of care hold significant hope for the promise of parity as they could act as a model for other plaintiffs pursuing civil action for wrongful behavioral health coverage denials. This litigation is still ongoing as the plaintiffs must now effectively demonstrate UBH failed to provide appropriate coverage to be reimbursed for care.⁴⁵ Nonetheless, *Wit v. UBH* signifies the most successful effort thus far in holding insurers accountable for their noncompliance with Federal Parity and their discriminatory actions which have resulted in disparate coverage for behavioral health services.

Table 11. Accepted standards of care cited by Judge Joseph Spero in *Wit v UBH*. (Adapted from Appelbaum et al. 2020)

Principles Constituting Accepted Standards of Care	
➤ Effective treatment requires treatment of the individual’s underlying condition and is not limited to alleviation of the individual’s current symptoms.	➤ When there is ambiguity as to the appropriate level of care, the practitioner should err on the side of caution by placing the patient in a higher level of care.
➤ Effective treatment requires treatment of co-occurring mental health and substance use disorders and/or medical conditions in a coordinated manner that considers the interactions of the	➤ The appropriate duration of treatment for mental health and substance use disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.

<p>disorders when determining the appropriate level of care.</p> <ul style="list-style-type: none"> ➤ Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration. ➤ Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective. 	<ul style="list-style-type: none"> ➤ The unique needs of children and adolescents must be taken into account when making decisions regarding the level of care involving their treatment for mental health or substance use disorders. ➤ The determination of the appropriate level of care for patients with mental health and/or substance use disorders should be made on the basis of a multidimensional assessment that takes into account a wide variety of information about the patient.
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Inadequate Access to Behavioral Health Services Persists Regardless of Policy

Regardless of progressive parity laws, type of insurance, or how comprehensive one’s insurance coverage may be, limited access to mental health and substance use services remains problematic and endemic to the health care delivery system. While unequal access to care is not a problem unique to the behavioral health sector, access to behavioral health services is disproportionately more limited than access to medical/surgical care according to a survey conducted by NAMI in 2015.⁴³

A large factor contributing to insufficient access to behavioral health care is an undersized behavioral health workforce relative to service needs. As of December 2020, a Health Resources and Services Administration (HRSA) report determined about 122 million Americans live in “service deserts”, or areas with a mental health care health professional shortage.⁴⁸ According to federal regulations, regions are considered to have a mental health provider shortage if the population-to-provider ratio is at least 30,000 to 1. For communities demonstrating an unusually high need for mental health services, this population-to-provider threshold is reduced to 20,000 to 1.⁴⁸ Especially impacted by mental health “service deserts” are rural communities who bear the burden of maldistribution in addition to behavioral health provider shortages.⁴³ Another study found

that 55% of U.S. counties do not have a single practicing mental health worker.⁴³ Due to the undersized and maldistributed behavioral health workforce, only 26.99% of the need for mental health providers has been met nationally and an estimated 77% of individuals with mental health conditions report an unmet need for care.^{38,48} Disconcertingly, HRSA projects immense shortages in behavioral health care providers relative to the demand for care will persist through 2030.⁴⁹

Aside from general mental health provider shortages, many individuals seeking behavioral health care struggle to find in-network clinicians who are accepting new patients. In fact, individuals seeking behavioral health services are six times more likely to defer to out-of-network behavioral health providers relative to other types of medical care.³⁸ This translates to individuals paying higher out-of-pocket costs for mental health and substance use services compared to other medical care. The disproportionate use of out-of-network substance use services is particularly jarring. A 2017 report by Milliman Inc. found inpatient facilities for substance use disorders were 10.1 times more likely to be used out-of-network relative to medical/surgical inpatient facilities. This rate of out-of-network inpatient facility use for substance use disorder treatment has more than doubled since 2013 when such facilities were 4.7 times more likely to be out-of-network relative to medical/surgical inpatient facilities. Similar trends in out-of-network outpatient facility use for substance abuse services were also observed.⁵⁰ Such undue high rates of out-of-network behavioral health service use are a direct result of network inadequacies and place greater financial strain on insured individuals.

One of the reasons for such limited networks is that insurers reimburse behavioral health providers less than they do providers in other specialties. The 2017 Milliman

report found primary care reimbursements were 24% higher than behavioral health reimbursements and in eleven states, primary care reimbursements were 50% higher.⁵⁰ This unequal reimbursement dissuades behavioral health providers from participating in network with insurers and causes network insufficiencies.

With poor reimbursement rates and network insufficiencies comes fewer behavioral health providers accepting insurance, be it private or public, and increased preference for patients willing to pay out of pocket for services. A 2014 study, for example, found that only 55.3% of psychiatrists nationwide accept private insurance relative to 88.7% of health providers in other specialties.⁴³ More recently, a 2020 study conducted in Massachusetts, a state with a larger number of psychiatrists relative to the national average and ranked highest in access to mental health care according to Mental Health America, reported only 6% of licensed psychiatrists in the state had filed insurance claims for a full caseload of patients.^{33,51} The study also noted most psychiatrists accept private health insurance for only a few patients per year and psychiatrists who have been in practice for several decades were more likely participate in private insurance networks relative to those with fewer years of practice. With nearly half of psychiatrists in Massachusetts approaching retirement age and more than 60% of practicing psychiatrists nationally over the age of 55, there are great concerns regarding access to behavioral health in the future should there not be a sufficient inflow of psychiatrists, especially those participating in insurance markets.^{51,52}

The prevalence of “service deserts” across the U.S. and lack of adequate behavioral health networks has resulted in long wait times and commutes for needed care, high rates of burnout among providers, and higher out-of-pocket costs for patients. With

an insufficient number of behavioral health providers to meet the demand of care, many patients must endure a long waitlist before seeing a clinician. One study conducted in Massachusetts reported over 50% of those seeking psychiatric services had to wait over one month before seeing a psychiatrist.⁵³ Another study of psychiatrists' availability in three major cities across the U.S. reported an average wait time of 25 days for an initial appointment.⁵⁴ Chronically long wait times for initial appointments, and even extended amounts of time between appointments, not only frustrate patients seeking care, but also behavioral health care providers. In 2019, wait times of up to two months for follow-up appointments due to insufficient provider-to-patient ratios drove mental health clinicians at Kaiser Permanente in California to strike for the fourth time since 2012. One of the psychiatrists on strike noted the long delays between sessions have clinical impacts, often prolonging symptoms and exacerbating a patient's condition.⁵⁵

Not only are patients experiencing long waits for services, many often must endure long commutes to receive in-clinic care. A 2018 study conducted by the National Council for Behavioral Health found that almost half of Americans (46%) had to travel over an hour roundtrip to obtain behavioral health treatment.³⁶ However, this barrier has been ameliorated through increased use of telehealth or teletherapy services, especially during the COVID-19 pandemic.⁵⁶ Physician burnout is another known and well documented concern among health providers of all specialties. In 2017, a Mayo Clinic study reported 36.9% of psychiatrists experienced burnout. In comparison, 28.1% of all American workers reported burnout.⁵⁷

While there are several factors which limit access to behavioral health care, it should be noted that access is inherently disparate due to varying social determinants of

health. Additionally, increased vulnerability to unfavorable social, economic, and physical environments has been proven to be directly correlated to increased risk for mental illness.⁵⁸ The relationship between mental health and socioeconomic status is multifaceted and creates a perpetuating and transgenerational cycle. For example, individuals with less socioeconomic capital are at greater risk for mental disorders which likely leads to insufficient income and employment, which in turn increases risk of poverty, and the cycle continues. It has been repeatedly proven that the risks and effects of mental illness can be mitigated or prevented through increased prevention and early intervention efforts.⁵⁸ America's current mental health prevention efforts are critically deficient simply because "population-based" prevention does not fit into the current healthcare financing and delivery system. Instead, greater focus is placed on treatment once symptoms reach crisis levels.⁵⁹ The impacts of insufficient prevention are profound as demonstrated by the continuous increase in prevalence of AMI, unemployment, incarceration, and most tragically, the unconscionably high and increasing rates of suicide in the United States.

Based on the evidence outline above, it is abundantly clear that limited access to behavioral health care persists, regardless of federal legislation, due to fundamental insufficiencies in insurance networks and the behavioral health care delivery system. Important additional steps must be taken to achieve true parity both in policy and practice.

CONCLUSION

As Former Representative Patrick Kennedy, one of the draftsperson and primary driving forces behind the MHPAEA, once detailed in a floor statement supporting the parity act, “access to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered from discriminatory treatment at all levels of society”.⁶⁰ While the MHPAEA coupled with the ACA can be viewed as legislative successes through both increasing the proportion of insured Americans and promising more equal coverage for mental health and substance use services relative to medical/surgical care, Former Representative Kennedy’s statement still holds true and access to behavioral health services remains a vital issue.

The current state of behavioral health in America is a crisis. Over one in five U.S. adults experience mental illness each year and more than half of all Americans seek behavioral health services. The prevalence of mental illness among Americans has been consistently increasing while service utilization has remained stagnant.¹ Furthermore, data from SAMHSA’s 2019 NSDUH saw a stunning trend of increased major depressive episodes among both adults and adolescents that was congruous with the observed increased rate of suicide attempts and deaths by suicide.¹ This not only underscores mental health as a major medical and public health concern, but also echoes the critical importance of mental health care and prevention. However, there is still a large unmet need for behavioral health services.

Despite the enactment of the MHPAEA and ACA, the persistent unmet need reflects the barriers to behavioral health services that appear to remain institutionalized

within the American health care delivery system. As it stands, not all insured Americans are provided the protections of behavioral health parity under the MHPAEA or ACA (Table 1).⁶¹ Underinsurance rates have increased since the ACA's inception. In combination with underinsurance, inadequate insurance networks and the behavioral health workforce shortage relative to need creates higher out-of-pocket costs, extensive provider waitlists, long commutes for care, and increased use of out-of-network services for behavioral health services. Unsatisfactory enforcement of Federal Parity has allowed for violations to go unnoticed, especially in regard to more restrictive NQTLs for behavioral health benefits. Unless a claimant has the wherewithal and resources to exercise their private right to enforce parity through civil action, issues of noncompliance can persist. Even so, the financial repercussions for insurers when found to not comply with parity are insignificant such that it can be cheaper for insurers to continue the use of discriminatory and more restrictive NQTL practices.

The limitations of the MHPAEA legislation are only part of the disconnect between policy and practice of parity however. Perpetuated by fears of financial loss among insurers and the stigmas of mental disorders, mental health care has been marginalized within the convoluted patchwork that is the American health insurance market. As a result, payment and coverage of behavioral health services is complex, poorly reimbursed, and riddled with red-tape which burdens both patients and providers. This subsequently contributes to inadequate insurance networks, increased use of out-of-network services for which patients must pay higher out of pocket costs. Furthermore, even if true parity were achieved and all other insurance-related barriers were resolved,

the shortage of behavioral health providers relative to need would still dramatically limit access to behavioral health resources.

Pointing out the factors that limit the extent of parity achievable in practice relative to current policy is not to undermine the progress made by the MHPAEA, but to underscore there is more work to be done before it can be concluded that true parity has been achieved. The bottom line is that the Federal parity legislation is not, nor could it be, well equipped to rectify all the pitfalls that plague the American health insurance and healthcare delivery systems relating to behavioral health care. Based on the history of behavioral health coverage in America, it is evident that the MHPAEA is a landmark legislation that leveled the playing field for behavioral health care by ensuring equal benefits for mental health and substance use services when offered. By doing so, the parity act profoundly stated that mental health is just as important as physical health and challenged long-standing discriminatory insurance practices against mental health and substance abuse benefits.

It could be argued that the MHPAEA was not designed to stand alone in the pursuit of true parity, but rather provided a foundation to be built upon by further parity legislation. In the same sense that the ACA expanded the reach of the MHPAEA, further legislation is required to improve behavioral health prevention, access, and coverage. Possible means for improvement include the integration of behavioral health services with primary care, improved enforcement of current parity provisions, more comprehensive insurance coverage, and increased transparency from insurance agencies. Moreover, further protections should be implemented to grant those insured through ERISA-exempt plans the right to exert private enforcement of parity and due process.

Lastly, legislation requiring *all* insurance plans to abide by the mandated parity approach intrinsic to the ACA's EHB coverage requirements instead of the MHPAEA's "mandated offering parity" approach would more soundly create universal behavioral health parity.

The overall understaffed behavioral health workforce present on a national level proves an important challenge to overcome. Better recruitment strategies and incentives for entering clinical psychiatry should be explored such as increased reimbursement rates and reduced administrative burden. Moreover, expanding the psychiatric prescribing workforce to advanced practice registered nurses, physician's assistants, and board certified psychiatric pharmacists could improve access to psychiatric medication management and reduce the burden placed on psychiatrists who currently hold the majority of this responsibility in most states.⁵³

It is likely future data for 2020 and 2021 will be reflective of the widespread hardships endured during the COVID-19 pandemic and will demonstrate significant increases in the prevalence of mental illness and depression among both adolescents and adults. With millions of Americans having filed for unemployment since the pandemic began, there will also likely be an increase in the number of uninsured and underinsured. With such anticipated increases in the prevalence of behavioral health conditions, it is also likely the aforementioned barriers, especially the understaffed behavioral health workforce, will intensify and become a more significant hindrance to mental health and substance use care accessibility. Arguably, there is no more critical a time than now to take substantial strides towards improving behavioral health parity. One can hope the mental health implications of the COVID-19 pandemic not only reduce the stigmas

associated with mental illness, but also rallies parity advocates to push for provisions that build on the MHPAEA so that the practice can finally match the policy of parity.

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