Bridging the Divide Between Health and Mental Health: New Opportunity for Parity in Childhood

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The modern era for mental health parity in the US began in 1996, when Congress enacted the Mental Health Parity Act (MHPA), which required equivalence in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. Mental health parity generally refers to the equal treatment of mental health conditions and physical health conditions in insurance plans, the substance of which extends far beyond equivalence in the dollar limits of benefits. Mental health parity is a foundational aspiration that has not yet been fulfilled in the US; this article describes details of subsequent legislation that has created new opportunity to finish the work that was started by MHPA, to achieve actual mental health parity, with particular reference to the needs of children.

MHPA was superseded by the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), which required health insurers covering more than 50 beneficiaries to guarantee that financial requirements on benefits (including quantifiable limitations such as co-pays, deductibles, and out-of-pocket maximums) were not more restrictive for mental health or substance use disorders than for medical or surgical conditions, for any plan that offered both. Albeit an important advance, these regulatory measures could not be applied to small insurance pools (fewer than 50 employees) or to "carve-outs" for mental health services, and fulfillment of MHPAEA was compromised by other barriers to care, including low reimbursement to providers, resulting in reduced numbers of providers willing to agree to be in-network.[1] Consequently, the aftermath of MHPAEA has been disappointing; a 2020 study of outpatient medical and psychiatric care highlighted a signature manifestation of failure to achieve parity: disproportionate reliance on self-pay.[2] The study covered 10 years of data from the National Ambulatory Medical Care Survey (NAMCS) to show that the proportion of all outpatient psychiatric visits that were self-pay actually rose from 2007 to 2016 from 18.5% to 26.7%. Children and adults were equally affected. The percentage of psychiatrists who worked in predominantly self-pay practices trended upward from 16.4% to 26.4% over that same period, in which the percentage of primary care clinicians who work in predominantly self-pay practices remained steady at 1.6%, a full order-of-magnitude difference between medical care and psychiatric care.

Typically, families do not self-pay for care for diabetes or asthma because they can access providers who provide quality care covered by their insurance. However, for mental health, providers of quality care covered by insurance are often so difficult to access that adequately resourced families are willing to pay for such service out of pocket, which has supported a cottage industry of outpatient mental health practitioners who do not participate in insurance networks. Lower-resourced families, particularly children insured by managed care organizations (MCOs) that execute Medicaid benefits under contract, are left to rely on what is available through their insurance. The findings of Benjenk *et al.*[2] depict what has become, in essence, a 2-tiered system for psychiatric care that is highly familiar to most readers of this *Journal,* in which patients who must rely on third-party payment for mental health care often compete for fragmented, delayed care from lower-reimbursed clinicians in chronically short-supply, whereas those who can self-pay are more often (but by no means always) able to receive higher-quality comprehensive care in a timely fashion. In essence, failure to fulfill the objectives of federal legislation that made mental health parity the law of the land has resulted in progressive accentuation of deficits in mental health equity, often most pronounced for children governmentally insured or with complex neuropsychiatric conditions.[3]

In late 2020 at the height of the COVID-19 pandemic, the Strengthening Behavioral Health Parity Act (SBHPA, H.R. 7539) was passed.[4] It required insurance companies to comply with federal or state requests to perform "comparative analyses" of the provision of mental health and medical/surgical services, and to make them available to the US

Department of Labor (DOL) and/or state insurance commissioners. Notably, the analyses extend beyond the monetary expenditures regulated by the former laws, to include Non-Quantitative Treatment Limitations (NQTLs) on mental health care, which are restrictions that are not expressed numerically but that nonetheless limit the scope or duration of benefits for treatment (Figure 1A). One of these is failure to reimburse providers at a level commensurate with (1) the geographic market, (2) the demand for service, and/or (3) the provider supply to ensure adequate capacity to deliver medically necessary mental health services to the members of the insurance network. In 2022, in my own (new) home State of Georgia, the Legislature unanimously passed House Bill 1013, requiring all private insurers in the state (including MCOs) to submit annual comparative analysis reports regarding their compliance with existing federal mental health parity legislation.

SBHPA represents new opportunity to advance implementation of mental health parity in childhood, as has been advocated internationally[5]: it attempts to ensure that (1) medically necessary psychiatric interventions are delivered to covered populations at a frequency that is in keeping with the demand in the insured population (ie, prevalence of the conditions for which the respective interventions are indicated); (2) reimbursement for a medically necessary psychiatric service represents the same proportion of the true cost of the service as for a covered medical service; and (3) provider reimbursement is adequate to attract into the network the number of providers necessary to meet the demand of the covered population, so-called "network adequacy." Each of these parameters is potentially recoverable in data maintained by a health system (Figure 1B).

How do these parameters play out for medical conditions? Typically, medical treatments are reimbursed at a level that is close enough to their true cost to make them sustainable for providers, and reimbursement to providers is adequate to attract enough in-network providers to deliver the medically necessary intervention to the individuals who need it. For most types of pediatric care, failure to deliver a medically necessary service results in legal or financial liability, except for highly specialized medical services and/or treatments of extremely high cost (eg, gene therapy) or fixed capacity constraints (eg, organ transplantation).

Standards for medical necessity do not play out this way in child mental health, however, unless there exists imminent risk of harm to self or other. As under-reimbursement of the true cost of care is pervasive, and as provider reimbursements are inadequate to attract enough members of a workforce in chronic shortage to participate in provider networks, non-availability of evidence-informed care has become commonplace and even an expectation of the child mental health system. The observations of Benjenk *et al.*[2] on disproportionate self-pay for behavioral health services are the consequence of this scenario and are worsening in the US, even as the demand for child mental health services continues to rise.[6] In Georgia, actuarial data have reportedly

FIGURE 1 Parameterizing Nonquantitative Treatment Limitations

A

--"examples of how specific evidentiary standards may be applied to each service category or classification of benefits" (a7Cv)
--"examples of methods of determining appropriate types of NQTLs pertaining to medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative" (a7CiI)
--"examples of methods of determining factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy"(a7CiiII)
--"examples of methods of reaching appropriate coverage determinations for new mental health or substance use disorder treatments, such as evidence-based early intervention programs for individuals with a serious mental illness" (a7Cvii)

B

	Psychiatric Diagnosis	*How often does this condition occur in the population of the insurance pool?*	*Which evidence-based interventions are medically indicated for this condition?*	*How often should this service be rendered to keep the population mentally healthy?*	*Is the service occurring as often as would be expected for known prevalence*	*Are there adequate numbers of providers in-network to meet the need?*	*Does the insurer cover the cost of this service?*
	Diagnostic Indication for Medically-Necessary (Evidence-based) Service	**Annual Incidence (Per 1,000 Covered Lives)**	**Medically-Necessary Evidence-Based Service**	**Expected Encounters/Yr Per 1,000 Covered Lives**	**Proportion of expected encounters per 1,000 covered lives ACTUALLY DELIVERED**	**Proportion of provider slots (work RVUs) necessary to meet expected demand that are actually available**	**Proportion of true cost of service, inclusive of care coordination, that is covered by insurer**
Example:	Major Depressive Disorder, F32	71	Management of established patient, CPT 99214	426	?	?	?

Note: (A) Selected examples of Non-Quantitative Treatment Limitations (NQTLs) specified by the Strengthening Behavioral Health Parity Act (SBHPA, H.R. 7539), which constitute violations of mental health parity if proved different between medical and mental health services within an insurance network. (B) Example of data fields relevant to monitoring a7CiiII (network adequacy) within a health system or insurance network.

suggested that children are forced to go out of network for behavioral health care over 10 times more frequently than for general medical care,[7] precisely in keeping with the data of Benjenk *et al.*[2]

Therefore, it is now incumbent upon national and regional leaders of our field to help define these parameters: that is, for providers, academic institutions, and health systems—individually or collaboratively—to clarify the demand and true cost of medically necessary mental health interventions, and for insurers to reimburse providers at a level that ensures adequacy within their provider networks to respond to the need. Quantitative parameters of network adequacy, such as requirements to have a minimum number of practitioners within a maximum radius of each insured patient's home (as established in some states) are not meaningful if the listed providers cannot accept new patients,[8] in which case they need to be replaced by NQTLs. In medicine, physicians are responsible for specifying (prescribing) medically necessary courses of treatment; patients are responsible for pursuing the recommended treatment (eg, picking up the prescription), and insurers are responsible for covering the costs, not only for the treatment itself but to ensure that enough providers are attracted to meet the need of the population. It should be no different for mental health care.

Systematic documentation of key indices of parity is of paramount importance[9] and can include the following: clarity over evidence-based services that are being recommended in treatment plans (Figure 1B); and implementation of routine follow-up of patients to determine whether recommended services were accessible and covered by the insurer, and if not, itemizing and reporting parity violations. Reporting parity violations are daunting for both patients and providers,[9] but SBHPA is designed to respond to parity information accrued within health systems. Ultimately, the objective is to promote adherence and partnership between insurers and providers to sustainably achieve mental health parity. It is important to consider also that resolution of other barriers to care (eg, certification and licensure obstacles for clinicians, transportation for patients), leveraging of technologies for improving efficiency in care delivery, and syndication of model efforts of successful community mental health programs are important facets of a comprehensive approach to deliver mental health care to all children according to standards that are on par with those that characterize their medical care.

In summary, SBHPA highlights new opportunity for the field of child psychiatry to promote systematic implementation of its evidence base. New phases of parity enforcement/fulfillment might initially focus on practice elements that have been shown to reduce catastrophic outcomes but can extend to early intervention services, which SBHPA includes as medically necessary when they demonstrably promote resilience or reduce risk of enduring impairment incurred by the mental health conditions that they are designed to ameliorate or prevent.

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REFERENCES

1. Presskreischer R, Barry CL, Lawrence AK, McCourt A, Mojtabai R, McGinty EE. Factors affecting state-level enforcement of the Federal Mental Health Parity and Addiction Equity Act: a cross-case analysis of four states. J Health Polit Policy Law. 2023;48(1):1-34. https://doi.org/10.1215/03616878-10171062
2. Benjenk I, Chen J. Trends in self-payment for outpatient psychiatrist visits. JAMA Psychiatry. 2020;77(12):1305-1307. https://doi.org/10.1001/jamapsychiatry.2020.2072
3. Zhu JM, Breslau J, McConnell KJ. Medicaid managed care network adequacy standards for mental health care access: balancing flexibility and accountability. JAMA Health Forum. 2021;2(5):e210280. https://doi.org/10.1001/jamahealthforum.2021.0280
4. H.R. 7539, 2020. 116th Congress (2019-2020): Strengthening Behavioral Health Parity Act. Accessed June 5, 2023. https://www.congress.gov/bill/116th-congress/house-bill/7539/text
5. World Health Organization. 2020 Helping Adolescents Thrive: guidelines on mental health promotive and preventive interventions for adolescents. Geneva: World Health Organization; 2020.
6. American Academy of Pediatrics. AAP-AACP-CHA declaration of a national emergency in child and adolescent mental health. 2021. Accessed June 5, 2023. https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/
7. Eldridge E. Georgia Public Broadcasting. Children's Healthcare of Atlanta is opening a 10-acre mental health center, thanks to donor funds. 2022. Accessed June 5, 2023. https://www.gpb.org/news/2022/11/14/childrens-healthcare-of-atlanta-opening-10-acre-mental-health-center-thanks-donor
8. Walsh MJ, Becerra X, Yellen JL. MHPAEA report to Congress: realizing parity, reducing stigma, and raising awareness; increasing access to mental health and substance use disorder coverage. 2022. Accessed June 5, 2023. https://docs.house.gov/meetings/IF/IF14/20220405/114583/HHRG-117-IF14-20220405-SD026.pdf
9. Kennedy Forum. Kennedy Forum, Filing and appeal based on a parity violation. 2017. Accessed June 5, 2023. https://www.thekennedyforum.org/app/uploads/2017/09/20170615-The-Kennedy-Forum-Filing-an-Appeal-Issue-Brief-Final.pdf