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Mental Health: Parity, the ACA, and Wellness Initiatives

Inside

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Five years after Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), the federal Departments of Labor, the Treasury, and HHS jointly issued a Final rule implementing the law. MHPAEA works to decrease differences in the way health insurance plans and providers cover benefits for mental health and substance use disorders—historically, there has been little to no coverage for non-medical/surgical benefits, while consumers were subjected to high payments and strict coverage limitations for any mental health and substance use benefits they did receive.

In the press release announcing the Final rule (78 FR 68240), Treasury Secretary Jacob J. Lew stated, "Americans deserve access to coverage for mental health and substance use disorders that is on par with medical and surgical care. These rules mark an important step in ending the disparities that exist in insurance plans, and will provide families nationwide with critical coverage and protections that fulfill their health needs." Similarly, Labor Secretary Thomas E. Perez said that "New efforts are underway to expand coverage to the millions of Americans who have lacked access to affordable treatment for mental and substance use disorders. These rules will increase access to mental health and substance abuse treatment, prohibit discriminatory practices, and increase health plan transparency."

Although the Final rule provided some much-needed clarity ensuring that health plan features like co-pays, deductibles, and visit limits are generally not more restrictive for mental health/substance use disorders benefits than they are for medical/surgical benefits, it does not guarantee total parity. To build on MHPAEA (P.L. 110-343, secs. 511-12), the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) provides additional requirements for health insurance plans that will increase access to affordable mental health and substance abuse treatment.

HHS Secretary Kathleen Sebelius said, "This Final rule breaks down barriers that stand in the way of treatment and recovery services for millions of Americans. Building on these rules, the Affordable Care Act is expanding mental health and substance use disorder benefits and parity protections to 62 million Americans. This historic expansion will help make treatment more affordable and accessible."

This White Paper focuses on the requirements of the Final rule, including the various measures of parity that plans must follow, the barriers that remain after publication of the Final rule, and how MHPAEA is affected by the ACA. It also includes a discussion of access to mental health care, particularly for children, and ways to improve access.

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Introduction

To understand the requirements of MHPAEA, it is first necessary to know the history of mental health and substance use benefits and the importance of parity.

History of mental health insurance. Mental health insurance is a relatively new concept. Although American communities began creating institutions for mentally ill individuals during the 18th century, institutions were either paid for privately or provided by the state. As the country's population increased, private asylums, psychiatric wards, and mental hospitals grew in number and size. By 1890, each state had at least one publicly supported mental hospital. Dr. Benjamin Rush, a signatory to the Declaration of Independence, published the first systematic textbook on mental diseases in America in 1812, *Medical Inquiries and Observations upon Diseases of the Mind*. In 1844, the American Journal of Insanity (now the American Journal of Psychiatry) began publication and the Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association) was organized. The first federal legislation funding services for the mentally ill, the Bill for the Benefit of the Indigent Insane, passed in 1854 but was vetoed by President Pierce. Close to a century passed before the introduction of more federal legislation on the topic.

In the aftermath of World War II, the nation began to consider mental health a federal issue. In 1946, the National Mental Health Act (P.L.79-487) was enacted, establishing the National Institute of Mental Health (NIMH). Around the same time, insurance companies began covering some hospital psychiatric services. The Joint Commission on Mental Illness and Mental Health, established by the Mental Health Study Act of 1955 (P.L. 84-182), issued a report that became the basis of the Community Mental Health Act of 1963 (CMHA) (P.L. 88-164). CMHA provided funding for grants to states, under NIMH's oversight, for the establishment of community mental health centers (CMHCs) to provide local-based care as an alternative to institutionalization. CMHA was never fully implemented; only half of the planned CMHCs were ever built and program funding was cut. The move away from institutions and toward CMHCs led to more insurance companies providing mental health services; however, limitations on beneficiaries' number and length of visits increased from 1963 until the early 1990s. Many employer-provided plans had higher cost sharing for mental health benefits than for general medical benefits. Individual states began requiring health insurance providers to cover some minimum mental health benefit levels, which led to a national push for mental health coverage.

Mental Health Parity

History of parity. In 1996, the federal legislature enacted the Mental Health Parity Act (MHPA) (P.L. 104-204), which required large group health plans (those with fifty or more employees) to apply the same lifetime and annual dollar limits to mental health coverage as those applied to coverage for medical and surgical benefits. MHPA did not require large group health plans to cover mental health; rather, it imposed the parity requirement only on those that chose to offer mental thealth benefits. It only applied to lifetime and annual dollar limits, and not to special annual day or visit limits or higher cost sharing. MHPA further did not cover the treatment of substance use disorders. Many health plans circumvented the spirit of the law by increasing restrictions on the number of hospital days and outpatient visits for mental health services. Although MHPA did little to provide parity for mental health coverage, the coverage it received led to many state initiatives requiring parity. Within 10 years, 37 states enacted parity laws. State parity laws vary widely in scope, covered benefits, included diagnoses, and the eligible population. State laws are not applicable to all insurance companies; the Employee Retirement Income Security Act (ERISA) of 1974 exempts firms that self-insure from state insurance mandates, including parity laws. Without a federal parity law, mental health coverage was not guaranteed and geographic location played a huge role in the type and amount of coverage individuals received. Multi-state employers faced difficulties in covering employees.

MHPAEA. In 2008, President Bush signed the Mental Health Parity and Addiction Equity Act (MHPAEA) into law. For plan years beginning after October 3, 2009, MHPAEA requires large employer-based health insurance plans (over 50 employees) to cover treatment for psychiatric illnesses and substance-abuse disorders in the same way that they cover treatment for diseases like cancer. It also prevents large group health plans from imposing annual or lifetime dollar limits on mental health or substance use disorder benefits that are less favorable than any such limits imposed on medical/surgical benefits. HHS issued an interim Final rule beginning MHPAEA implementation on February 2, 2010; when the comment period ended May 3, 2010, HHS

had received 5,400 comments. The federal government did not publish a Final rule until five years after the Act was passed; HHS, jointly with the Departments of Labor and Treasury, issued a Final rule on November 13, 2013, implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) (P.L. 110-343, secs. 511-12).

MHPAEA Final Rule

The Final rule includes consideration of and responses to the comments submitted by the public, and ensures that health plans features like co-pays, deductibles, and visit limits are generally not more restrictive for mental health/substance use disorders benefits than they are for medical/surgical benefits. It clarified the scope of service, including the application of parity to all plan standards, including geographic limits, facility-type limits, and network adequacy. The rule further eliminated the "clinically recognized standard of care" exception that the interim rule created, and applied parity to intermediate levels of care received in residential treatment or intensive outpatient settings.

The new regulations are effective on Jan. 13, 2014, except for certain technical amendments effective on Dec. 13, 2013. The mental health parity provisions of the final regulation apply to group health plans for plan years (or, in the individual market, policy years) beginning on or after July 1, 2014. Until that time, plans and issuers must continue to comply with the interim final regulations, which are effective for plan years beginning on or after July 1, 2010.

Required parity. MHPAEA requires insurance plans to cover mental health and substance use disorder benefits to the same extent and in the same manner as coverage for medical and surgical benefits. In general, plans may impose limitations and requirements on mental health and substance use disorder benefits as long as those limitations and requirements are also placed on medical and surgical benefits. As long as all benefits are treated similarly, plans may impose financial requirements (including deductibles, copayments, coinsurance, and out-of-pocket limits) and quantitative treatment limitations (such as frequency of treatment, number of visits, days of coverage, or other scope and duration of treatment limits. The only requirement to achieve parity is that the requirements or limitations can be no more restrictive than the "predominant" financial requirements or treatment limitations applied to "substantially all" medical/surgical benefits. Similarly, plans may impose nonquantitative treatment limitations (NQTLs), or limits that are not expressed numerically; mental health and substance abuse benefits NQTLs must be comparable to, and applied no more stringently than, those imposed with respect to medical/surgical benefits.

MHPAEA requires insurance plans to cover mental health and substance use disorder benefits to the same extent and in the same manner as coverage for medical and surgical benefits.

Predominant/substantially all test. The predominant/substantially all test was first announced in the interim final regulations. It applies on a classification-by-classification basis, based on six benefits classifications:

- inpatient, in-network;
- inpatient, out-of-network;
- outpatient, in-network;
- outpatient, out-of-network;
- emergency care; and
- prescription drugs.

These six classifications, plus the sub-classifications specifically described in the regulations, are the only permissible classifications. Outside of these classifications, no benefits may be categorized. In-network benefits may be subclassified into tiered networks for the application of parity rules to the financial requirements and quantitative treatment limitations. Any tiers must be based on reasonable factors, and without regard to whether a provider provides mental health/substance use benefits or medica/surgical benefits. Further, any financial requirement or quantitative treatment limit on mental health or substance use benefits in any subclassification cannot be more restrictive than the predominant financial requirement or quantitative treatment limit that applies to substantially all medical and surgical benefits in the subclassification. Subclassifications are specifically prohibited for generalists and specialists by the Final rule.

NQTLs. The Final rule confirms a separate parity requirement for NQTLs, which are limitations that are more subjective than those regulated by the predominant/substantially all test. Examples of NQTLs include:

- network tier design;
- restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;
- medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; formulary design for prescription drugs;
- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods for determining usual, customary, and reasonable charges;
- refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
- exclusions based on failure to complete a course of treatment.

To be considered comparable, the processes, strategies, evidentiary standards and other factors used for NQTLs cannot be specifically designed to restrict access to mental health or substance use disorder benefits. Plan standards must be applied in a manner that complies with the Final rule. Such standards may include in- and out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, and exclusions for services provided by clinical social workers.

Clinically appropriate standards of care. The Final rule eliminated an exception that had been included in the Interim final rule: the exception allowed NQTLs to provide variation in benefit levels "the extent that recognized clinically appropriate standards of care may permit a difference." The federal government determined that the exception was confusing, unnecessary, and subject to abuse. The Final rule, however, *does not* require plans and issuers to use the same NQTLs for mental health/substance use disorder benefits and medical/surgical benefits. According to the preamble, "disparate results alone do not mean that the NQTLs in use do not comply with these requirements." MHPAEA requirements will be met as long as the processes, strategies, and standards for NQTLs are comparable and no more stringently applied.

Increased cost exemption. Under the MHPAEA, if certain requirements are met, plans incurring increased costs of at least 2 percent in the first year of MHPAEA application, or at least 1 percent in any subsequent year, may be exempt from the statutory parity requirements. The Final rule adopts standards and procedures for claiming the increased cost exemption. Among other requirements, the plan or issuer must provide notice of the exemption to the participants, the federal Departments of Labor, the Treasury, and HHS, and appropriate state agencies. In conjunction with the Final rule, the Departments of Labor, Treasury, and HHS issued FAQs providing contact information for plans and issuers to send notices.

Shortcomings of MHPAEA and the Final Rule

Limited applicability. The most noticeable omission in MHPAEA is that the Act and its regulations do not apply to all health plans. Under MHPAEA, large employer-based health insurance plans (over 50 employees) *that choose to offer mental health and substance use disorder coverage* must cover such treatment in the same way that they cover treatment for diseases like cancer. There is no requirement for any insurance plans to cover mental health or substance use disorders. In addition, large group health plans are prohibited from imposing annual or lifetime dollar limits on mental health or substance use disorder benefits that are less favorable than any such limits imposed on medical/surgical benefits. MHPAEA does not apply to individual or small employer plans, church-sponsored plans that are exempt from the Employee Retirement Income Security Act (ERISA) (29 U.S.C. sec. 1003(b)(2)), self-insured plans sponsored by state and local governments, or retiree-only plans. Furthermore, on its face, MHPAEA does not apply to Medicaid, Medicare, TRICARE, or the Children's Health Insurance Program (CHIP).

In January 2013, CMS released a letter that discussed application of MHPAEA to Medicaid non-managed care benchmark and benchmark-equivalent plans (Medicaid Alternative Benefit plans), CHIP, and Medicaid managed care programs provided by managed care organizations (MCOs). The letter states (1) "all Medicaid Alternative Benefit plans are required to meet the provisions within MHPAEA regardless of whether

services are delivered in managed care or non-managed care arrangements;" (2) "for CHIP programs, mental health and substance use disorder parity requirements apply to all delivery systems, including fee-for-service and managed care;" and (3) "mental health and substance use disorder parity requirements apply to MCOs that contract with the state to provide both medical/ surgical and mental health or substance use disorder benefits." The letter details some exceptions for MCOs to the extent that the benefits offered reflect the limitations and requirements set forth in the Medicaid state plan and specified in CMS approved contracts. The letter's requirements are not reflected in the Final rule, leaving uncertainty as to how these plans must provide parity and to what extent.

Scientifically-validated treatment. Under the Final rule, a health plan is allowed to require coverage only of mental health treatments that it believes has scientific merit as long as the plan has a committee that evaluates the scientific merit of medical treatments. Parity only requires that a plan provides mental health treatments that are largely equal to the medical or surgical benefits offered by the plan. In many cases, however, mental health is a much less exact science than medical treatment. While a pill that reduces cholesterol works substantially the same in most patients, a pill that decreases symptoms of depression may achieve results in far fewer patients. Because psychiatrists do not yet have a full understanding of the causes of many mental illness, many treatments are experimental or otherwise not-yet-scientifically validated; such treatments need not be covered by health plans, so long as medical treatments are covered similarly. As Thomas Insell, M.D., Director of the National Institute of Mental Health, explained, "the problem for new therapies for mental disorders is not only lack of compounds but lack of understanding of the targets for treatment development. Existing antidepressants and antipsychotics have many proposed molecular targets, but none that have been shown to be necessary or sufficient for their clinical effects. Amazingly, after three decades of broad use of these medications, we still don't know how they work when they are effective." The ability of providers to deny coverage of experimental or other treatments that a committee finds to be lacking scientific merit poses a problem that will need to be addressed.

Intermediate levels of care. The regulations provide six allowable classifications ((1) in-patient, in-network; (2) in-patient, out-of-network; (3) out-patient, in-network; (4) out-patient, out-of-network; (5) emergency care; and (6) pharmacy benefits) for coverage; within classifications, there must be parity between medical or surgical benefits and mental health or substance use disorder benefits. The Final rule, however, does not address how the six benefit classifications apply to intermediate levels of care, such as residential treatment facilities, partial hospitalization, or intensive outpatient treatment. In the preamble to the Final rule, the Departments of Labor, the Treasury, and HHS stated that although they "did not intend that plans and issuers could exclude intermediate levels of care covered under the plan from MHPAEA's parity requirements," they also "did not intend to impose a benefit mandate through the parity requirement that could require greater benefits for mental health conditions and substance use disorders than for medical/surgical conditions." Therefore, intermediate benefits for mental health and substance use disorders must be assigned to benefit classifications in the same way that comparable medical and surgical benefits are assigned. Instead of providing specific requirements, the Final rule allows the plan or issuer to classify intermediate levels of care. The lack of an enunciated regulation may cause problems as individual plans or insurers attempt to interpret the vague rules.

Under the ACA, mental health and substance use disorder services is one of 10 essential health benefits (EHBs) that must be covered.

Mental Health Parity and the ACA

ACA expansion of coverage requirements. The ACA builds on MHPAEA, requiring more coverage of mental health and substance use disorders. Under the ACA, all non-grandfathered health plans in the individual and small group markets must comply with the parity requirements. Furthermore, the regulations are no longer only applicable to those plans that choose to provide mental health coverage; mental health and substance use disorder services is one of 10 essential health benefits (EHBs) that must be covered.

Essential health benefits. The ACA amended the Public Health Services Act (PHS) to prohibit the

imposition of annual or lifetime dollar limits on coverage of EHBs. Because of this amendment, the Final rule implementing MHPAEA had to address the interaction between MHPAEA and the ACA. The Final rule states "the parity requirements regarding annual and lifetime limits described in these final regulations only apply to the provision of mental health and substance use disorder benefits that are not EHB." According to the Final rule, this "greatly reduces the instances in which annual or lifetime limits will be permissible."

It is not yet clear which benefits fall into the definition of "not EHB" because EHB has not been specifically defined. The Final rule suggests that the Departments of Labor, Treasury, and HHS will take a lenient approach determining which mental health and substance use disorder services qualify as EHB or not EHB. As long as a plan uses a definition of EHB "authorized by the HHS Secretary," the definition will be considered permissible. The Departments stated that they "intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB," and referred readers with additional questions about authorized definitions to a CMS FAQ document about EHBs.

The preamble to the Final rule provides further clarification: although the MHPAEA regulations exempt individuals and small employers (those that employed no more than 50 employees during the previous calendar year), the EHB regulations issued under the ACA require that non-grandfathered individual and small group plans comply with the MHPAEA regardless of the small-employer exemption. Therefore, MHPAEA applies to such plans that would only be exempt as small employers, despite the seeming exemption.

Preventive health services. The ACA also requires that non-grandfathered group health plans provide coverage for specified preventive services without cost sharing. These services include alcohol misuse screening and counseling, depression counseling, and tobacco use screening. The preamble to the Final rule notes that compliance with the ACA's preventive care requirements should *not* require a group health plan or insurance provider to provide a "full range" of mental health and substance use disorder benefits under MHPAEA. Accordingly, group health plans or insurance providers that cover mental health and substance use disorder services only to the extent required by the ACA are not required to provide additional mental health or substance disorder benefits in any of the six classifications.

Access to Mental Health Care

In Illinois, there is a teenage boy living in his car feeling helpless and alone. Tim lived his entire life in the wake of his mother's bi-polar disorder, moving from a six-bedroom home while she was married to his father to various one-bedroom apartments while supported by state welfare after his parent's divorce. He suffered verbal abuse from both his mother during the low points of her depression and from kids at school who made fun of his lunch program purchases. For years, he had seen therapists to deal with his anger issues and depression. Despite his mother's passing, he managed to graduate high school and earn scholarship money for an essay he wrote. A family friend pulled some weight to get him into Illinois' 360 Youth Services program, which offers counseling and free tuition for community college if troubled youth follow the program rules. But, it was too late. Tim's self-esteem had been so badly damaged, he turned down the opportunity for a new life and success for homelessness and substance abuse. In Nevada, there are several homeless youth programs, but there are increasing numbers of homeless teens frequenting the streets and walking amongst cars at stoplights in over 100-degree heat hoping for any spare water, food, or money. Why?

Factors of Mental Illness

There are many influences in a child's personal, family, social, and cultural environment and development that may lead to mental illness, such as exposure to violence, family instability, or poverty, which often stretch into adulthood and result in a pattern of substance abuse. Child Trends, a nonprofit research center for children and youth health, refers to these negative developmental factors as "toxic stress," which have been reported to change brain structure and function and negatively affect children's cognitive and social skills, according to the organization's July 2014 report, titled, "Are the Children Well? A Model and Recommendations for Promoting the Mental Wellness of the Nation's Young People."

The report emphasizes that mental health in children has not improved over the years despite increased scientific and media attention to and identification of mental health conditions and development of pharmaceuticals to treat them. While some attention to this

problem has been given by HHS, the Substance Abuse and Mental Health Services Agency (SAMHSA), and the ACA, the Child Trends report asserts that instead of being reactive to children's mental health issues, health care providers and policymakers need to take a proactive approach to eliminate the disconnect between mental and physical health wellness, the result of which has serious consequences. These include direct and indirect economic costs. The government annually spends $24.3 billion on mental health services and $100.1 billion on related health care costs. It is also estimated that the annual total lost earnings for adults with mental illness is about $193.2 billion.

The National Alliance on Mental Illness (NAMI) supports the Child Trends report stating that while there is no cure for mental illness, there can be recovery with proper ongoing treatment that includes a combination of traditional elements of mental health treatment, medication, as well as physical health "as another cornerstone of wellness." More importantly, NAMI asserts Medicaid and its expansion play a crucial role in mental health service financing and delivery as well as in offering coverage to an "estimated 2.7 million uninsured people affected by mental illness." According to NAMI, "Medicaid is the largest source of financing public mental health services, accounting for nearly 50 percent of all public sector spending."

Sobering statistics. In its Medicaid and CHIP: May 2014 Applications and Eligibility Determinations, and Enrollment Report, CMS reported that of the 38 states that submitted the Children's Health Insurance Program (CHIP) data, children make up approximately 56 percent of CHIP and Medicaid enrollment, equaling about 26.4 million children. The most recent June 2014 Monthly Applications, Eligibility Determinations, and Enrollment Report showed a slight increase in 40 states of 27 million enrolled children (see *June enrollment tops 600,000*, August 13, 2014). Of the many sobering statistics that relate to children and teens, The National Institutes for Health (NIH) and the NAMI shared these facts dated 2012 to 2013:

- Approximately 20 percent of 13- to 18-year-olds experience severe mental disorders in a given year. For ages 8 to 15, the estimate is 13 percent (*NIH*).
- Seventy percent of youth in juvenile justice systems have at least one mental health condition and at least 20 percent live with a severe mental illness (*NAMI*).
- Almost 50 percent of kids aged 8 to 15 who had a mental illness received no mental health services in *2013* (NIH).
- 50 percent of all chronic mental illness begins by the age of 14 (75 percent by age 24).
- NIH also provided other agency statistics including:
- Over 50 percent of mentally ill students age 14 and older who are served by special education have the highest dropout rate of any disability group (*U.S. Department of Education*, 2006).
- More than 90 percent of those who commit suicide had one or more mental disorders (*American Association of Suicidology*, 2012).
- From the January 2010 Point-in-Time counts (PIT), Continuums of Care (CoCs) reported that 26.2 percent of sheltered homeless adults had a severe mental illness, and 34.7 percent had a chronic substance abuse problem (U.S. Department of Housing and Urban Development's (HUD) 2010 Annual Homeless Assessment Report (*AHAR*) to Congress).

ACA's Stance on Mental Health

For those on Medicaid, ACA sec. 1413 addresses funding and procedures for enrollment through a Health Insurance Exchange (Exchange), state Medicaid, CHIP, and health subsidy programs. Sec. 1413 applies to underserved populations and provides that "comprehensive primary health services" include not just physical health treatments, but also mental health and substance abuse treatment, assessments, crisis intervention, counseling, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs. Is this ACA provision enough to ensure that children dealing with "toxic stress" will get the help they need?

Medicaid and its expansion play a crucial role in mental health service financing and delivery as well as in offering coverage to an "estimated 2.7 million uninsured people affected by mental illness."

EHBs and mental health. In February 2013, HHS issued a Final rule (78 FR 12834) expanding the ACA to

require Exchanges and issuers to cover mental health and substance use disorder services as one of the 10 essential health benefits (EHB) categories for the individual and small group markets. Section 1302 of the ACA implemented an EHB package that includes coverage requirements, cost-sharing limits, and actuarial value requirements of any health plan.

With the goals of health plan affordability, comprehensiveness, and fairness in mind, the Final rule, effective April 26, 2013, mandates that EHBs be equal in scope to the benefits covered by a typical employer plan and cover at least the following 10 general EHB service categories as defined by the HHS Secretary: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services (see *ACA has limited impact on excluded medical services list,* March 12, 2014). Sections 1302(b)(4)(A) through (D) of the ACA also require that the HHS Secretary design the 10 EHBs (1) to hold equal balance among categories; (2) to prevent discrimination based on age, disability, or life expectancy; (3) to account for the health care needs of diverse population groups; and (4) to not deny EHBs based on age, life expectancy, or disability.

Finally, the Final rule set benchmark approaches to plan options to include those used in Medicaid (42 C.F.R. sec. 440.330) and in CHIP (42 C.F.R. secs. 457.410 and 457.420). According to HHS, however, as of 2013 the small group market plans were more likely to cover mental health issues than individual private plans, but mental health and substance use disorder services and habilitative services were the least likely to be covered in the general market.

Parity. Under 2014 parity requirements, all health plans, including those sold through Exchanges or Marketplaces, must offer coverage of mental health services comparable to coverage of medical and surgical benefits (see *ACA supports increased coverage of mental health services,* May 7, 2014). These ACA requirements comply with MHPAEA, which established the parity requirements, but did not apply them to health plans that did not provide any coverage for mental health care or to companies with less than 50 employees. According to NAMI, some states enacted mental health parity legislation as a direct result of the Sandy Hook Elementary School shooting in December 2012. There is no dispute that the event put mental health treatment and its failings in the spotlight.

Contributing Factors to Medicaid's Mental Health Barriers

Despite the ACA's efforts, there are several contributing factors keeping mentally ill youth from receiving much needed help through state programs. Although this discussion contains only a brief mention of some basic factors at the governmental level, it is important to note the three top factors cited by afflicted individuals are cost, a belief that they are able to handle the problem without treatment, and a lack of resource or service location knowledge. Based on reported deep cuts to state Medicaid spending, these three factors are not unfounded.

Lack of Medicaid expansion. According to research by the Urban Institute, a nonprofit social and economic policy research organization, 24 states have not yet expanded their Medicaid services, potentially depriving themselves of billions of federal dollars and leaving six million people without health care coverage in 2016. This is an unfortunate fact, as the ACA allows opportunity for substantial economic boosts to states that expand their Medicaid eligibility to nonelderly members of families that earn less than 133 percent of the federal poverty level. By refusing to expand Medicaid, unwilling states are diminishing economic activity and job growth. Their hospitals also are losing roughly $168 billion in Medicaid revenue. The organization has conducted financial analyses showing that Medicaid expansion would generate revenue that would surpass Medicaid costs.

In a follow-up report to its March 2011 report titled, "State Mental Health Cuts: A National Crisis," NAMI released "State Mental Health Cuts: The Continuing Crisis," in November 2011 to document the deep cuts to state spending on services for mentally ill children and adults. The report cites California, Illinois, Nevada, and South Carolina as having made additional cuts for fiscal year (FY) 2012 on top of previous impactful cuts reported in 2009. These states' devastating reductions in mental health services culminated in losses of vital services such as housing, community treatment, access to psychiatric medications, and crisis services.

Nevada example. Nevada is one such state that has experienced a lack of in-state services. Between FYs 2009 and 2012, Nevada reduced its mental health services by

28.1 percent. The lack of inpatient psychiatric services forces Nevada to send an average of 50 mentally ill children and teens to other states for treatment; in some years the number has been as many as 200 youths. As of March 2014, Desert Willow Treatment Center, had only 58 beds and is the only public hospital providing Clark County youths with residential treatment. Personnel who work with the children and teens who need such psychiatric services have said that "the facility cannot meet the demand."

Faulty Medicaid pay structure. Access to mental health services seems to be discouraged by a complicated payment system. The earlier referenced Child Trends report emphasized a need for a payment structure that focuses on the importance of mental wellness services, despite instances where children do not have diagnosable conditions. Child Trends sees fee-for-service billing and third-party billers as the culprits in preventing physicians from making certain mental illness diagnoses, even when a physician may notice a change in patients' behaviors. Payments made by both public and private insurers are structured around reimbursement for services linked to a specific disorder diagnosis because insurance plans subject mental health issues to separate authorization criteria. There are few incentives to providers to treat chronic mental illness.

Insurance requirements. Barriers to mental health care access also exist because mental health services are often subjected to many specific requirements for authorization, provider selection, benefit caps, deductibles, and co-pays that regular services are not. Melanie Dillon, owner of the Illinois-based Center for Wellness, Inc., noted that in the wellness community, there is talk that "finding a doctor who takes Medicaid is difficult. When you do find one, there is likely a wait list. Basically, [Medicaid] services generally equate to a longer wait time to get in ... Some subsidized agencies have a better record for getting kids in than the local health departments who are usually understaffed."

Negative attitudes. The subjection of mental health services to insurance companies' scrutiny becomes another barrier to care in its own right. The subjection translates to prejudice or negative attitudes toward mental illness. According to an August 2014 posting in The Seattle Times, Washington had adapted the Mental Health Parity Act, but insurance companies have found loopholes to covering mental illness. "Insurers still impose blanket exclusions on medically necessary mental-health care, limit their networks of mental-health providers and impose barriers to coverage under the guise of 'utilization review.'" Some consumers are travelling many miles and hours to get the covered mental-health services they need due to the insurance companies' exclusions. The exclusions are apparently being left out of policy text and typically apply to only mental health services. Whatever is covered is subjected to review criteria, which usually does not include chronic mental disorders such as personality disorder or post-traumatic stress disorder.

"Insurers still impose blanket exclusions on medically necessary mental-health care, limit their networks of mental-health providers and impose barriers to coverage under the guise of 'utilization review.'"

Some Solutions to Access Barriers

Earlier the question was whether ACA provisions would be enough to help mentally ill children who are covered by Medicaid. Certainly, the ACA has several mental health provisions such as mental health parity; the inclusion of mental health and substance abuse services in essential benefits packages; grant funding implementation for training additional mental health care professionals and community health centers; the requirement that private insurance plans for dependents and foster children under Medicaid remain eligible for coverage up to age 26; and required preventative service coverage. It seems that social media and recent spotlights on tragic events have sparked increased concern about those with mental illness.

New federal solutions. Several new federal initiatives were announced in a May 2014 fact sheet for eliminating mental health barriers. Among the initiatives are:

- funding of $115 million for training more mental health professionals to serve in our communities and increase mental illness education and awareness;

- reducing the cost barrier by expanding insurance coverage for mental health services;
- reducing negative attitudes and perceptions about mental illness so people are willing to seek help; and
- investing in research to seek new treatments.

The fact sheet explained that these new initiatives would expand benefits for mental health and substance use disorders to approximately 60 million Americans. Vice President Joe Biden stated that the Fiscal Year 2014 Omnibus Appropriations Bill secured $115 million for professional training and included a provision that aims to help educators recognize the early signs of mental health problems and refer young people to appropriate help when needed.

In December 2013, the administration announced it would allocate $100 million in funding to improve access to mental health services, $50 million of which aided 200 community health centers to establish or expand behavioral health services. The other $50 million was allocated to the construction, expansion, and improvement of mental health facilities in rural areas.

Further, the Child Trends organization noted other federal program initiatives such as the Mental Health First Aid (MHFA) program which grants $15 million to school districts and state education departments to provide professional readiness training; $40 million for 20 Project AWARE (Advancing Wellness and Resilience in Education) grants that will support school treatment programs; and the Centers for Disease Control and Prevention's (CDC) Community Transformation Grants that will provide funding to states that promote healthy lifestyle habits.

Finally, Child Trends' recommended remedy to the payment structure issue is the use of Accountable Care Organizations (ACOs), a payment model that Medicare and some state Medicaid programs are testing. ACOs are large connected groups of health providers that are assigned a caseload of patients. "ACOs are penalized for poor outcomes within that group, and rewarded for good ones." According to Child Trends, this model shifts the payment system away from fee-for-service billing to outcome-based billing to encourage preventive care.

State-level solutions. The Council of Economic Advisors (CEA) released a report along with the Urban Institute that pointed to the several benefits of expanding Medicaid eligibility, including improved health care access, better preventative care, financial security, improved mental health, and healthy state economies. States have taken their own legislative measures to promote mental wellness in areas such as their criminal justice systems, community mental health programs, and inpatient treatment protocols.

Further, the May 2014 Medicaid and CHIP Report, noted earlier, reported that all 50 states, and the District of Columbia, were in the process of simplifying their enrollment, application, and eligibility protocols as well as improving eligibility determinations by designing new technology to be data focused as mandated by sec. 2201 of the ACA, effective January 1, 2014. Alabama, Colorado, Kentucky, New York, and Utah made notable contributions to real-time eligibility determinations and relevant system upgrades. The May 2014 Medicaid enrollment report also noted that since Michigan expanded Medicaid on April 1, 2014, the state's total enrollment grew more than 10 percent between March and May 2014. Additionally, the June 2014 Medicaid and CHIP: Monthly Applications, Eligibility Determinations, and Enrollment Report indicated that Medicaid enrollment in expanding states rose by 18.5 percent and only by four percent in nonexpanding states. States making efforts to expand Medicaid benefits should be reaching more troubled youths, and that is good news.

Nevada's new resolve. As for Nevada, new focus has been given to its troubled mental health system. The state announced on July 21, 2014, that a new building for HELP for Southern Nevada Youth Center was in the works to alleviate overcrowding of homeless youth. The youth center is certified to provide Level III Inpatient residential and Level I Outpatient drug and alcohol treatment and mental health referrals. NAMI also reports that in 2013, Nevada took measures to expand the use of assisted outpatient treatment by allowing court orders for outpatient treatment when it is determined that a person has a mental illness and is likely to harm himself or others if left untreated. The law requires courts to place ill individuals into "the most appropriate course of community-based treatment available" (AB 287). In August 2013, the Interim Finance Committee approved $2.1 million in emergency mental health funding as an answer to overcrowded emergency rooms and loss of one hospital's accreditation and quality staff. The state still faces hurdles, but these steps are a good start.

California's Efforts

ACA's impact on California. To further explore the current issues surrounding state governmental barriers to and initiatives for mental health services for children, Wolters Kluwer posed several questions to the former

California Medicaid Director, Gail L. Margolis, who is now Vice President of Government, Business and Community Relations for the Children's Hospital Los Angeles. Margolis' responses center around the environment in California and children in particular.

In your experience, what ways have the above barriers been addressed previously and how successful had those efforts been?

Margolis: Funding for mental health services in California is carved out from public health and, therefore, patients need to navigate two systems at once.

Many experience the 'silo-ing' of the Departments of Mental Health, "Physical Health," and Public Health. Counties', states', and federal programs historically have operated these mental and physical health programs independently. Further, these governmental agencies act independently of each other (more on this part below). Wherever there is a collaboration of these entities, outcomes improve. Many community clinics have worked diligently to join the disciplines early in the diagnostic process. Just as Community clinics are closer to the communities they serve from cultural and linguistic proficiency, they are savvy to the psychological needs of the community.

Comprehensive health centers recognize the need for early identification and treatment of nonphysical signs and symptoms, especially for families in poverty. Community-based programs often design their services around a community needs assessment. No one walks into a clinician's office stating, "the seemingly obvious physical problem is a manifestation of my psychological issues." Clinics (and others) that are focused on the whole child are much quicker to look for, and find, underlying mental health issues—whether exhibited by the child or a family member. In my own experience, both the Venice Family Clinic and Eisner Pediatric and Family Medical Center astutely assess, identify, and treat behavioral health issues from the first visit.

What changes do you expect to see under the new federal funding initiatives in terms of access to services for mentally ill children participating in Medicaid?

Margolis: The Affordable Care Act (ACA) encourages the parity of mental health services by integrating behavioral health services with primary care.

Mental health service navigators support the alliance of these disciplines, resulting in looking at the whole person. ACA encourages the ability to correctly identify the root cause of the problem using evidence-based practices by inclusion of one's mental state from the start. In adults we see more of the "worried well," but these issues arise in children and may be projected onto them by their parents. The California Exchange (Covered California) and particularly the expansion of the Medicaid program to adults may increase the diagnosis and treatment for parents (and potential parents) with behavioral health issues earlier, thereby improving a child's environment.

"Another obstacle is the paucity of behavioral/mental health trained providers, especially those proficient in other languages and cultures—this is more than an obstacle; it represents a cliff."

Children with one parent with mental health needs were three times as likely to have mental health needs as those whose parents did not.

What do you see as obstacles to the new initiatives?

Margolis: There remains the issue of underestimating the need for behavioral health services. UCLA just last month [July 2014] published a Policy Brief noting that "three out of four children with mental health needs do not receive treatment despite having health care coverage." Such behavioral health needs are exacerbated by poverty, physical illness/disability, and family illness or disability. Further, UCLA, among others, reports that the obstacles encountered prior to the implementation of the ACA in 'navigating the multiple systems of care' to receive mental health services as 'daunting for families and thus may deter or delay families and children from receiving timely care'. Hopefully, the intent of the ACA will be actualized. In addition, policy makers in Sacramento define the system, but administrative responsibility for delivering the services is provided by the counties. Another obstacle is the paucity of behavioral/mental health

trained providers, especially those proficient in other languages and cultures—this is more than an obstacle; it represents a cliff.

What additional steps would you want the federal government to implement to improve mental health services for children?

Margolis: HHS recently awarded a $54 million grant to establish or expand behavioral health services in health centers—a very good start. There needs to be more. In California, this means 32 health centers share a total of almost $8 million—a foundation on which to build, but ongoing financial sustenance is imperative. As in other aspects of the ACA, an insurance card does not equal access. To augment the number of professionals in the pipeline requires additional resources, both in the form of university debt reduction (in exchange for working in community clinics) and increasing reimbursement for services (modeling US SB 2012, which extends the ACA 'bump' of Medicaid's reimbursement floor to that of Medicare for primary care providers, pediatricians, and Ob/Gyns). Enhancing inpatient reimbursement for behavioral health hospitalizations might encourage more hospitals to convert medical-surgical beds to those with a behavioral health diagnosis. Presently, there are only 712 inpatient psych beds for children under 12 in the entire state of California. Finally, we need to fill the gap in linguistic and cultural competence.

In your opinion, how can success of these initiatives be achieved relative to children and teens?

Margolis: As with all patients, the family is relevant; however, in children and adolescents the family is absolutely the critical component. The family must act first as a supportive and loving structure, then as objective witnesses and historians to behavior, triggers, etc., and ultimately as active participants and collaborators. Families can reinforce positive care plan components in real time. It is the family as a whole that needs professional support. Previously mentioned, but worth repeating, is the essential respect of the diversity of families and their children. Collaboration requires trust and respect by the child and the family members to the team of practitioners, whether supporting physical or behavioral diagnosis.

What thoughts do you have on this subject that you would like to add?

Margolis: The ACA—here known as Covered California—has had a very successful start, reducing uninsured persons from about 22 percent to about 11 percent. As the former Medicaid Director in California, I am delighted to see the expansion of this program.

Conclusion

Together, MHPAEA and the ACA have greatly increased the accessibility of insurance coverage for individuals with mental health or substance use disorders. Although some details of implementing the parity requirements of the two laws are lacking, many Americans who previously had been without affordable mental health and substance use disorder coverage will be able to obtain treatment. Providers, plan issuers, and employers must be aware of the requirements of MHPAEA and understand how to determine whether or not their coverage complies.

Fifty percent of Americans will experience some mental health concern at some point in their lives, with most initiated during childhood; therefore, the promotion of health and mental wellness standards is important. The topic of mental health illness and Medicaid's barriers to mental health treatment is immense, and this report only scratches the surface of a few of its causes and solutions. It seems, however, that Medicaid expansion, departmental collaboration, and federal funding are key factors in reaching so many mentally ill youths. The government has talked the talk, but Tim and the Nevadan homeless kids can only hope it will indeed walk the walk.