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MENTAL HEALTH PARITY: MORE IMPORTANT THAN EVER POST-COVID

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I. INTRODUCTION

As we celebrated our second anniversary, my wife Caroline, suffered her first panic attack. Caroline spent the next week praying and speaking to every loved one in her life, but she could not find any reprieve from her anxiety; she felt helpless when her anxiety spiraled out of control. With nowhere else to turn, Caroline confided in our pastor, who recommended that she see a mental health counselor. The counselor discovered some root causes of Caroline's anxiety, uncovered by the COVID-19 pandemic, but ultimately found that Caroline was suffering from biological depression and would need to go see a psychiatrist—more time and money. This was a tough pill to swallow for Caroline, who was already overwhelmed (and having spent hundreds of dollars on treatment). As she soon learned, psychiatry is a process of trial and error, so she would spend the next ten months trying various medications that did not work; all of this was expensive and largely not covered by insurance. Nearly a year later, Caroline has finally found a promising medication, but the whole experience has taught her that the past year would have been much easier if she received preventative mental health treatment before her anxiety and depression spiraled out of control.

Like Caroline, many Americans spiraled into a pit of anxiety and depression because the COVID-19 pandemic exposed preexisting mental health conditions.[1] Studies "reported that the spatial distancing, self-isolation, quarantine, social and economic discord, and misinformation (particularly on social media) are among the major contributing factors towards unusual sadness, fear, frustration, feelings of helplessness, loneliness, and nervousness."[2] The Centers for Disease Control and Prevention ("CDC") acknowledged that the measures it recommended led to ill effects on mental health; on its website, there is an entire section dedicated to coping with mental health related stress and how "[p]ublic health actions, such as social distancing, are necessary to reduce the spread of COVID-19, but they can make us feel isolated and lonely and can increase stress and anxiety."[3]

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[1] Kiran Shafiq Khan et al., *The Mental Health Impact of the COVID-19 Pandemic Across Different Cohorts*, INT'L J. MENTAL HEALTH & ADDICTION, July 9, 2020, at 380, https://link.springer.com/article/10.1007/s11469-020-00367-0.

[2] *Id.*

[3] Nat'l Ctr. For Immunization and Respiratory Diseases, *CDC Stacks: Coping with Stress*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 22, 2021), https://stacks.cdc.gov/view/cdc/100876.

Moreover, a Kaiser Family Foundation ("KFF") "Health Tracking Poll from July 2020 [concluded] that many adults are reporting specific negative impacts on their mental health and well-being, such as difficulty sleeping (36%) or eating (32%), increases in alcohol consumption or substance use (12%), and worsening chronic conditions (12%), due to worry and stress over the coronavirus."[4] KFF research found that the average percentage of adults who reported symptoms of depression and/or anxiety increased from 11% in January 2019 to 41.1% in January 2021.[5] Another study, which anonymously examined 318 psychiatric patients, found "worsening of [existing] psychiatric conditions during the COVID-19 pandemic based on identification of new symptoms that necessitated clinical interventions such as dose adjustment or starting new medications in more than half of the patients."[6] Though an entire paper could be spent describing the effect of pandemics on mental health, these statistics illustrate that the "COVID-19 pandemic has given rise to even greater challenges for an already struggling system of mental health care."[7]

Issues with the mental health care system are not a new thing. Congress has been trying to reach mental health parity—equal coverage of mental health care—since the 1990s, when they passed the 1996 Mental Health Parity Act ("MHPA").[8] The MHPA raised awareness for mental health reform, but left many gaps to be filled because the MHPA only creates parity standards for dollar and lifetime limits and left loopholes that the insurance companies exploited.[9] To expand coverage to substance abuse and remedy the loopholes, Congress passed the Mental Health Parity and Addiction Equity Act ("MHPAEA") in 2018.[10] Though another step in the right direction, the MHPAEA was lacking because it only "requir[ed] comprehensive standards for equitable coverage of mental health and substance use disorder treatment and coverage of medical/surgical treatment."[11] Two years later, Congress passed the 2010 Affordable Care Act ("ACA"),[12] which was the most comprehensive mental health care reform to date because it "further expanded the reach of the parity laws by requiring [that] most health plans cover mental health and substance use disorder care and expanding the scope of MHPAEA to reach

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[4] Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, KAISER FAM. FOUND. (Feb. 10, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

[5] *Id.*

[6] Susanna Gobbi et al., *Worsening of Preexisting Psychiatric Conditions During the COVID-19 Pandemic*, FRONTIERS IN PSYCH. (Dec. 16, 2020), https://www.frontiersin.org/articles/10.3389/fpsyt.2020.581426/full.

[7] *Id.*

[8] Sarah Goodell, *Mental Health Parity*, HEALTH AFFAIRS (Apr. 3, 2014), https://www.healthaffairs.org/do/10.1377/hpb20140403.871424/full/.

[9] *Mental Health Parity: NAMI Public Policy Position*, NAT'L ALL. ON MENTAL ILLNESS (Mar. 2021), https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Mental-Health-Parity-for-web-3-2021.pdf.

[10] *The Mental Health Parity and Addiction Equity Act (MHPAEA)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet (last visited Oct. 27, 2022).

[11] *Mental Health Parity: NAMI Public Policy Position*, *supra* note 9.

[12] *What is the Affordable Care Act?*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/answers/affordable-care-act/what-is-the-affordable-care-act/index.html (last visited Oct. 27, 2022).

most small group and individual market[place]" health plans.[13] Among other things, the ACA required certain plans to expand coverage of mental health related services, expanded access to prescription drugs, and increased coverage of preventative care services such as counseling.[14]

Still, there is a supply shortage of doctors and clinics willing to provide mental health services, so patients have a tough time finding someone to treat their condition.[15] Once inside the mental health professional's door, patients still have to figure out how they will pay for treatment, because all mental health professionals are expensive and many do not take insurance.[16] As such, this paper argues that true mental health parity has not been achieved in the United States because the interaction of insurance companies and doctors hinders accessibility to mental health care services. This paper will further argue that high demand for mental health care services is decreasing the supply of doctors who take insurance, so the shortage will become worse unless insurance companies change the way that they cover and reimburse mental health services.

Part II provides a background of mental health parity laws and the unique needs of the mental and behavioral health care industries. Part III provides a deeper understanding of the roadblocks to mental health parity, including the counterarguments made by the insurance industry. Finally, Part IV explains how the United States can achieve mental health parity by utilizing alternative staffing measures to temporarily satisfy demand and ditching insurance companies' one size fits all approach to increase the supply of mental health providers

II. HISTORY OF MENTAL HEALTH PARITY AND ITS UNIQUE NEEDS

There has long been a debate that mental health—health of the brain, the very important organ that the neck attaches to every human's head, shoulders, knees, and toes—is not as important as physical health. For instance, go to the doctor with a broken arm and there will be little question about insurance coverage: one presents their insurance card, pays the applicable copay, and is out the door with a cast. In contrast, it is overly difficult to find a mental health provider that accepts insurance. "Public health care programs and private health insurers have long provided less comprehensive insurance benefits to individuals with mental illness in both the inpatient and outpatient settings."[17] This problem arose from public benefits programs such as Medicaid to private health insurance, where coverage for mental illness was either non-existent or extremely limited.[18]

In the private plan context, "[p]rior to health care reform, some health plans voluntarily included insurance benefits for mental illness; however, many of these plans

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[13] *Mental Health Parity: NAMI Public Policy Position*, *supra* note 9.
[14] Louise Norris, *How Obamacare Improved Mental Health Coverage*, HEALTH INS. (Nov. 13, 2020), https://www.healthinsurance.org/obamacare/how-obamacare-improved-mental-health-coverage/.
[15] *Id.*
[16] *Id.*
[17] Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1, 2 (2012).
[18] *Id.* at 5–7.

imposed higher cost-sharing requirements," including higher out of pocket costs (deductibles, copay, coinsurance, etc), limits on inpatient and outpatient visits, and both lifetime and annual caps on spending for mental health.[19] Now, mental health professionals are refusing to accept insurance because they do not want to deal with the administrative burdens, such as paperwork, recordkeeping, and low reimbursement rates[20] that come with accepting health insurance.[21]

The problems surrounding unequal insurance coverage of mental health has been recognized since the early 1990s, after which Congress passed the Mental Health Parity Act of 1996 ("MHPA") to help alleviate those problems. The MHPA "applied to large employer-sponsored group health plans (those with more than fifty employees) and prohibited them from imposing" dollar limits on mental health services that were less favorable than those limits imposed on surgical or medical benefits.[22] However, the MHPA did not require mental health coverage, it just required parity if the insurance company chose to cover mental health.[23] Moreover, plans otherwise covered by the MHPA were exempt from the requirements if they could prove that "the application of [the MHPA] to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent."[24] While certainly a step in the right direction, the MHPA failed to address limits on number of treatments and facilities covered, issues with cost sharing, and managed care techniques that allowed insurance companies to make mental health coverage less favorable than other types of treatment. "For example, a plan could set a limit of ten visits for therapy to treat major depression or charge a higher copayment for an outpatient visit for a mental health treatment than for a physical ailment without violating the law."[25]

Like the MHPA that preceded it, the Mental Health Parity and Addiction Equity Act of 2008 is a federal law that "generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits."[26] The key difference between the MHPA and the MHPAEA was that the MHPAEA closed a few loopholes and ultimately made requirements for parity stricter and expanded the law's reach to treat substance abuse and drug addictions.[27]

Two years later, Congress took mental health parity a step further with the Affordable Care Act of 2010 by requiring the majority of plans to actually cover mental

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[19] *Id.* at 7.

[20] Insurance companies have power of the purse and won't always pay doctors for the entirety of the services that they provide. *See infra* pt. III.

[21] Heather Levin, *The Rise of Cash-Only Doctors Who Don't Take Insurance – Pros & Cons*, MONEY CRASHERS (Dec. 6, 2018), https://www.moneycrashers.com/cash-only-doctors-no-insurance/; *see infra* pt. III.

[22] Goodell, *supra* note 8.

[23] *Id.*

[24] Mental Health Parity Act, Pub. L. No. 104-204, § 712, 110 Stat. 2874, 2947 (1996).

[25] Goodell, *supra* note 8.

[26] *Mental Health Parity and Addiction Equity Act (MHPAEA)*, *supra* note 10.

[27] *Id.*

health services.[28] The ACA expanded its reach to all insurance plans in the individual and small-employer market, both outside and inside of the health insurance marketplace.[29] Thus, plans in the jurisdiction of the ACA "must cover: behavioral health treatment[,] such as psychotherapy and counseling[,] mental and behavioral health inpatient services[,]" treatment for substance abuse, and coverage of *all* preexisting conditions.[30] This ultimately resulted in an extraordinary expansion of mental health and substance use disorder coverage because the ACA expanded coverage by about twenty million people and reduced the number of people who lacked mental health care due to cost constraints by one-third.[31]

As such, Americans should have more access to mental health care than any other time in history, but most Americans still struggle to find in-network coverage if they need mental health care.[32] Unfortunately, the pandemic has fueled demand for mental health services, so the shortage will likely get worse before it gets better.[33] "An estimated 122 million Americans, or 37% of the population, lived in 5,833 mental health professional shortage areas as of March 31[, 2021]"; the United States "needs an additional 6,398 mental health providers to fill these shortage gaps," with two-thirds of the shortage areas located in rural areas of the country.[34] As Part III will discuss, even if insurance companies are in technical compliance with the parity laws, it is still likely that many mental health treatments will go largely uncovered because the heavy demand for mental health services has led to a decrease in the amount of mental health providers who take insurance.[35]

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[28] *Health Benefits & Coverage: Mental Health & Substance Abuse Coverage*, HEALTHCARE.GOV, https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/ (last visited Oct. 27, 2022) (differing from the MHPA and MHPAEA, which required parity but not coverage).

[29] *Id.*

[30] *Id.*

[31] *What the Affordable Care Act Has Meant for People with Mental Health Conditions —And What Could Be Lost*, NAT'L ALL. ON MENTAL ILLNESS 2 (Nov. 2020), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/What-the-Affordable-Care-Act-Has-Meant-for-People-with-Mental-Health-Conditions-What-Could-Be-Lost/NAMI_IssueBrief_ACA_11-10-20.

[32] Dania Douglas et al., *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity*, NAT'L ALL. ON MENTAL ILLNESS 2–3 (Nov. 2016), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf.

[33] *CDC Stacks: Coping with Stress*, *supra* note 3.

[34] *Over One-Third of Americans Live in Areas Lacking Mental Health Professionals*, USA FACTS (last updated July 14, 2021, 2:54 PM), https://usafacts.org/articles/over-one-third-of-americans-live-in-areas-lacking-mental-health-professionals/.

[35] *See infra* pt. III.

III. ROADBLOCKS TO MENTAL HEALTH COVERAGE AND WHAT THE INSURANCE COMPANIES HAVE TO SAY ABOUT IT

Despite increased insurance coverage of mental health services, the road ahead is still both rocky and expensive—demand for mental health professionals is severely outpacing supply and older professionals are retiring faster than younger professionals are replacing them.[36] A 2020 study by GoodTherapy estimates that there will be shortages of 15,400 psychiatrists, 26,930 mental health counselors, and 57,940 psychologists by the year 2025.[37] The national average of psychiatrists to Americans is roughly nine psychiatrists per one-hundred thousand Americans.[38] More alarming is the fact that two-thirds of all primary care providers report trouble finding mental health specialist referrals and demand for psychiatrists might exceed supply by six thousand to fifteen thousand psychiatrists in the next five years.[39] This data suggests that mental health professionals are becoming a hot commodity in today's market, thus they can likely refuse to take insurance and still keep a full book of business.

Doctors that do not accept insurance,[40] also known as "cash only doctors," were prominent until the 1950s "when commercial insurance turned patient care into a profitable business."[41] This pay-as-you-go model is catching on with doctors because "[c]ash-only doctors have complete freedom in how much time they spend with each patient and what they charge for that time," while insurance often has stringent requirements from doctors ranging from high administrative burdens to declining reimbursement rates for services.[42] The insurance companies have the power of the purse and act as a boss to the doctors, forcing them to cram as many patients into their day as possible just to stay afloat.[43] One study found that some hospitals require their doctors to see a different patient every eleven minutes, while another study found that most doctors spend the majority of their busy day doing administrative tasks (paperwork, reviewing insurance-required lab work, and interacting with staff), leaving only twelve percent to seventeen percent of their day to actually interact with patients.[44]

Short visits are detrimental to the doctor-patient relationship because it is nearly impossible for the patient to open up to the doctor and meaningfully describe their problems; "[s]horter visits also mean that a patient is likely to leave with a prescription

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[36] *Is There a Shortage of Mental Health Professionals in America?*, GOOD THERAPY (last updated Mar. 26, 2020), https://www.goodtherapy.org/for-professionals/personal-development/become-a-therapist/is-there-shortage-of-mental-health-professionals-in-america.
[37] *Id.*
[38] *Solutions to Solving the Mental Health Shortage*, CROSS COUNTRY LOCUMS (June 11, 2021), https://www.crosscountrylocums.com/blogs/solutions-to-solving-the-mental-health-provider-shortage.
[39] *Id.*
[40] Steve Hargreaves, *Cash-Only Doctors Abandon the Insurance System,* CABLE NEWS NETWORK (June 11, 2013), https://money.cnn.com/2013/06/11/news/economy/cash-only-doctors (explaining how the cash only model leads to equity issues because only those with sufficient financial resources can access mental health).
[41] Levin, *supra* note 21.
[42] *Id.*
[43] *Id.*
[44] *Id.*

instead of knowledge about behavioral changes that might make more of an impact, simply because the doctor doesn't have time to have those conversations."[45] Short visits are even more problematic when treating mental illnesses such as depression and anxiety because psychiatric treatment is a trial and error process.[46] Doctors must combine their experience with facts provided by the patient to find the most likely medication to work, but the trial and error process requires the patient to try three to six different medications to find the ideal medication.[47] However, this problem requires time and interaction with the psychiatrist because most medications take a few weeks to show benefit or detriment to the patient and the optimum dose can vary.[48]

The pandemic-driven anxiety and depression has only made this problem worse because it has exponentially increased demand for mental health services.[49] Demand for mental health care in metropolitan areas is so strong that therapists just aren't accepting insurance—they can easily fill up their practice with those paying out of pocket, without having to worry about the administrative headaches that come with accepting insurance.[50] "Psychologists, social workers and psychiatrists who don't accept insurance say that insurers' reimbursement rates are too low" because insurance reimbursements equate to one-half to one-third of the fee that could be charged to out-of-pocket patients; mental health providers can take home twice as much profit by only accepting cash.[51] This presents a cyclical conundrum because as the number of cash only mental health providers grows, the demand for in-network providers[52] will increase. In theory, the in-network providers will follow the cash only doctors' lead, because as their practice grows, they can also fill their schedules with profitable patient meetings.

Even if a patient can find room on an in-network provider's schedule, there is yet another obstacle: medical necessity. "Insurance companies can easily circumvent mental health parity mandates by imposing restrictive standards of medical necessity."[53] This is because insurance companies often will only cover enough care to stabilize the patient following a mental health crisis. For example, plaintiffs in the class action, *Wit v. United Behavioral Health*, challenged United Behavioral Health ("UBH") for arbitrary and

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[45] *Id.*

[46] Devon Schuyler, *Trial and Error*, L.A. TIMES (Aug. 3, 2009, 12:00 AM), https://www.latimes.com/archives/la-xpm-2009-aug-03-he-depression-drug-choice3-story.html.

[47] *Id.*

[48] *Id.* This problem is further complicated with psychiatric drugs because there are typically unwanted side effects such as weight gain, flattened mood, and decreased libido. *Id.* Doctors and patients need time and communication to find the optimum medication and dose that makes the patient feel the most normal. *Id.*

[49] Andrea Petersen, *Why It's So Hard to Find a Therapist Who Takes Insurance*, WALL ST. J. (Oct. 5, 2021), https://www.wsj.com/articles/why-its-so-hard-to-find-a-therapist-who-takes-insurance-11633442400.

[50] *Id.*

[51] *Id.*

[52] "[P]roviders or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount." *What Does In-Network Mean?*, HEALTH INSURANCE.ORG, https://www.healthinsurance.org/glossary/in-network/ (last visited Oct. 27, 2022).

[53] Graison Dangor, *'Mental Health Parity' Is Still An Elusive Goal In U.S. Insurance Coverage*, NAT'L PUB. RADIO (June 7, 2019, 5:00 AM), https://www.npr.org/sections/health-shots/2019/06/07/730404539/mental-health-parity-is-still-an-elusive-goal-in-u-s-insurance-coverage.

capricious denial of benefits.[54] The plaintiffs alleged "that they were improperly denied benefits for treatment of mental health and substance use disorders because UBH's Guidelines do not comply with the terms of their insurance plans and/or state law."[55] The court found that UBH improperly denied plaintiffs benefits because while generally accepted standards of care necessitated treatment of the underlying causes of the plaintiffs' conditions, UBH would only provide enough coverage to alleviate the plaintiffs' current symptoms.[56] The court also found that UBH designed its coverage guidelines to cut costs rather than protect plan member interests.[57] On appeal, United Behavioral Health was able to get the district court decision reversed on grounds that the plans did not require consistency with generally accepted standards of care ("GASC").[58] The court noted that "[t]he Plans exclude coverage for treatment inconsistent with the GASC; Plaintiffs did not show that the Plans mandate coverage for all treatment that is consistent with the GASC."[59] The *Wit v. United Behavioral Health* decisions present a perfect example of an insurance company placing short-term cost savings over patient wellbeing; this appears short-sighted because mental wellbeing is associated with lower overall long-term health costs per patient.

Studies have shown that plan costs increase across the board when mental health conditions are left untreated, but most insurance companies cite costs as the number one reason for not covering mental health services.[60] Among other things, insurance companies assert that there is a moral hazard when it comes to mental health services: "individuals who do not pay for 100% of the cost of their own mental health care will use more mental health services because they do not value these services at their full cost."[61] To combat the moral hazard, the insurance companies impose higher deductibles, copayments, and coinsurance amounts, while also limiting the number of visits covered.[62] However, these claims are unfounded and based on an outdated study, because more recent studies have disproved this theory by finding that raising deductibles and coinsurance amounts has negligible impact on the moral hazard and mental health care demand.[63]

Further, some studies have found that increasing preventative mental health treatment will decrease the overall cost of mental health coverage. For example, an individual with a severe mental illness, such as schizophrenia, might require comprehensive treatment in an in-patient setting and exceed the policy's in-patient

[54] No. 14-CV-02346-JCS, 2019 WL 1033730, at *5 (N.D. Cal. Mar. 5, 2019). Though the plaintiffs' challenge was filed on Employee Retirement Income Security Act grounds, the court analyzed how UBH coverage guidelines deviated from the behavioral health profession's generally acceptable standards of care. *Id.*
[55] *Id.* at *1.
[56] *Id.* at *17; *see also* Levin, *supra* note 21 (noting that patients are more likely to leave with a prescription rather than behavioral changes that will improve their mental wellbeing).
[57] *Wit*, 2019 WL 1033730, at *53.
[58] Wit v. United Behavioral Health, No. 20-17363, 2022 WL 850647 at *2 (9th Cir. Mar. 22, 2022).
[59] *Id.*
[60] Tovino, *supra* note 17, at 9–10, 13–15.
[61] *Id.* at 10.
[62] *Id.*
[63] *Id.* at 10–11.

maximum days; when he or she leaves the facility due to lack of coverage and subsequently attempts suicide, that same individual is now requiring treatment in the emergency room—the most expensive setting of them all—to stabilize his or her condition and prevent further physical harm.[64] Other "researchers found that the patients diagnosed with depression had higher [total] annual health care costs ($4,246 versus $2,371), and 50% to 75% higher costs for every category of care setting," such as primary care, lab work, specialists, etc.; "[t]he researchers concluded not only that the diagnosis of depression was associated with a twofold increase in [the] use of health services but also that the greater medical utilization [of treating the patient's physical issues] exceeded the costs that would be associated with treating the depression."[65]

Thus, research indicates that the insurance company's claims are unfounded. Aside from the fact that providing accessibility to mental health services will decrease a patient's overall health care costs, patients will also have a better quality of life because they can finally receive help for their condition. The bottom line: insurance companies and mental health providers are working against each other when they should be collaborating with each other.

IV. THE SOLUTION—RETHINKING REIMBURSEMENT AND GROWING THE PROFESSION

Patients already struggle enough during a mental health crisis, so policy makers need to improve mental health care access. The problem is twofold: insurance companies are not providing enough mental health coverage and there is a shortage of professionals willing to enter the mental health care field. If insurance companies flooded the profession with funds, then opportunistic individuals would enter the profession to chase those funds, but that transition would take time. However, motivating professionals with money is not the best method to attract talent because the best mental health providers genuinely care about their patients, create a trusting bond with their patients, and prescribe *love* first, which is the best medicine.[66] Thus, the mental health profession needs to find a way to attract professionals that will wholeheartedly devote themselves to their patients through intrinsic motivation.[67]

The most obvious long-term solution is promoting the profession and raising awareness for the importance of mental health. At a grassroots level, the mental health profession can accomplish this by encouraging local school boards to offer basic psychology courses to younger children; this would generate interest for mental health and teach the children how to understand their own mental wellbeing.[68] Post-secondary

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[64] *Id.* at 13–14.

[65] *Id.* at 15–16. A second study by the same researchers compared depression in older adults to an increase in general health care costs; they had similar findings that depression increased overall health costs. *Id.* at 17.

[66] Michael Sperber, MD, *10 Hallmarks of a Great Psychiatrist*, PSYCHIATRIC TIMES (July 15, 2015), https://www.psychiatrictimes.com/view/10-hallmarks-great-psychiatrist?page=11.

[67] *See id.*

[68] Amy Curletto, *How to Teach Students About Mental Health*, JAMES STANFIELD BLOGS (August 29,2022 1:37 PM), https://stanfield.com/teaching-mental-health/#:~:text=Blogs,By%3A%20Amy%20Curletto. This

institutions can offer generous scholarships to students in pursuit of the mental health profession, so those that are concerned about the cost of education are not barred from the field before they begin. On a broader level, Hollywood can also generate interest for the mental health profession by creating mental-health-centered media.[69]

To solve the shortage in the short term, especially in rural areas, the industry needs to increase the use of other strategies such as retraining of staff, locums, and telehealth.[70] For example, New York State has 612 psychiatrists per 100,000 people, while Idaho has 1 psychiatrist per 100,000 people.[71] Policy makers should consider temporary solutions to close this gap.

First, the mental health profession can increase the utilization of telehealth services for mental health patients.[72] This was one silver lining that came from the pandemic because it led to "the emergence and adoption of remote therapy and treatment through telehealth, both in urban and rural areas[;] . . . providers and patients were adapting to technology that allows for treatment for those in both densely and sparsely populated areas in the country." [73] Telehealth, though not a permanent solution, can help bridge the mental health gap in rural versus urban areas. While many insurance providers, states, and the federal government are beginning to recognize the added benefits of telehealth, services delivered via telehealth typically are either covered less often or have higher out-of-pocket costs.[74] Luckily, twenty-six states have parity laws that "require private insurers to reimburse healthcare providers for services delivered through telemedicine" and ten additional states are considering similar legislation.[75]

On a federal level, administrative guidance can help ensure that the remaining states and Medicare also implement these measures, which will provide better access for

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is of even greater importance now with the rise of social media. *See* The Journal, *The Facebook Files, Part 2: 'We Make Body Image Issues Worse'*, WALL ST. J. (Sept. 14, 2021), https://www.wsj.com/podcasts/the-journal/the-facebook-files-part-2-we-make-body-image-issues-worse/c2c4d7ba-f261-4343-8d18-d4de177cf973. According to Facebook's internal study of Instagram, teenage girls have an increased risks of mental health issues, such as body image, eating disorders, anxiety, and depression, because Instagram influencers place a large focus on beauty and perfectionism. *Id.*

[69] One example of this is the film, *A Beautiful Mind*, which is based on a true story about John Nash, a schizophrenic mathematician that won a Nobel Prize for revolutionary work on the game theory of economics. A BEAUTIFUL MIND (Universal Pictures, DreamWorks Pictures, and Imagine Entm't 2001). Nash experiences various types of treatment and quits his antipsychotic medication due to frustration with its side effects. *Id.* The film was widely popular and exposed the public to the various struggles of a mental health patient and the fact that someone with mental health issues can still accomplish remarkable things. *Id.*

[70] CROSS COUNTRY LOCUMS, *supra* note 38.

[71] *Id.*

[72] Telehealth is a service that uses video calling and other technologies to help patients see their doctor or other health care provider from home instead of at a medical facility. *Telehealth: What Is It, How to Prepare, Is It Covered?*, NAT'L INST. ON AGING (last updated Aug. 26, 2020), https://www.nia.nih.gov/health/telehealth-what-it-how-prepare-it-covered. Telehealth is particularly helpful for older adults because they don't have to leave the safety of their homes and patients in rural areas because they don't have to travel a long way to find a doctor. *Id.*

[73] CROSS COUNTRY LOCUMS, *supra* note 38.

[74] *Will My Insurance Cover Telemedicine?*, CHIRON, https://chironhealth.com/definitive-guide-to-telemedicine/telemedicine-info-patients/will-insurance-cover-telemedicine/ (last visited Oct. 27, 2022).

[75] *Id.*

those patients in rural areas. In the meantime, locum tenens psychiatrists, doctors working temporarily outside of their own practice, can move to high demand rural areas until full-time psychiatrists permanently fill the roles.[76]

Next, Psychiatric Mental Health Nurse Practitioners ("PMHNPs"), who require far less education than doctors, can care for most patient needs as long as they are supervised by a psychiatric doctor; as such, each psychiatric doctor's practice can care for a greater number of patients.[77] PMHNPs[78] bill time at a lower rate than psychiatric doctors, so PMHNPs can spend greater amounts of necessary time with patients while alleviating some of the concerns that insurance companies have regarding costs.

As mentioned in Part III, mental health treatment requires more face-to-face interaction with the patients than other fields of medicine, but insurance companies push doctors to see one patient every eleven minutes;[79] this presents a problem because patients that already struggle to open up to the doctor about their anxiety or depression are less likely to do so when they feel rushed.[80] Thus, the use of PMHNPs can serve as a middle ground between insurance companies and parity advocates because PMHNPs can spend more time with the patients at a lower cost to insurance companies when compared to face-to-face interaction with psychiatric doctors.

Licensing requirements for the nursing industry are set at the state level, so this solution will only work if state nursing boards update their licensure requirements and make it easier for existing nurses and nurse practitioners to become PMHNPs. In 2016, Florida state officials recognized the shortage of mental health professionals, so they passed HB 977 to allow PMHNPs, known as psychiatric nurses in Florida, to gain licensure to treat mental health conditions and prescribe psychiatric medications.[81]

Psychiatric nurses require less education than psychiatric doctors, so they can enter the mental health field more quickly.[82] The psychiatric nurse designation carries a lot of weight, especially during a time of shortage, because psychiatric nurses can prescribe psychotropic medications used to treat mental health disorders like anti-anxiety medication and antidepressants.[83] While this law was a step in the right direction, it only helps incoming nurse practitioners who have not yet completed their master's degree because it requires a specialization in the psychiatric field.

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[76] CROSS COUNTRY LOCUMS, *supra* note 38. This helps with problems relating to insurance coverage because insurance companies typically cover locum tenens services. *See id.*

[77] *See id.*

[78] The terminology varies when designating nurse practitioners. In general, a nurse practitioner, is a type of advance practice registered nurse ("APRN") which means that the nurse has obtained a master's degree in nursing. NurseJournal Staff, *NP vs APRN: What's the Difference?*, NURSEJOURNAL (Updated May 9, 2022), https://www.nursepractitionerschools.com/resources/np-vs-aprn/.

[79] Levin, *supra* note 21.

[80] *Id.*

[81] *Important Legislative Update Regarding HB 977*, FLA. BD. OF NURSING (Apr. 19, 2016), https://floridasnursing.gov/important-legislative-update-regarding-hb-977/.

[82] The relevant statute states that "'[p]sychiatric nurse' means an advanced practice registered nurse certified under s.464.012 who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 2 years of post-master's clinical experience under the supervision of a physician." FLA. STAT. § 394.455(36) (2022).

[83] FLA. STAT. § 464.012(4)(e) (2022).

Consequently, Florida and other states should consider creating laws that accelerate the transition to mental health for experienced nurse practitioners. Policy makers could allow existing nurse practitioners to enroll in an accelerated program that leverages the nurse practitioners' experience and knowledge, rather than the masters in psychiatric nursing and two years under a psychiatrist that the Florida Statute ordinarily requires.[84] This would help address the more immediate need for mental health professionals.

Finally, any further laws and regulations must address the fact that delivery of mental health treatment differs from delivery of medical surgical treatment. As discussed in Part III, insurance companies place a high emphasis on cost savings, and this causes their coverage to deviate from the mental health profession's generally accepted standards of care.[85] Patients suffer both financially and physically because the insurance companies only provide coverage to stabilize the condition; if patients want to find the root cause of their problems to prevent future mental health crises, then they often have to challenge the insurance company or pay out of pocket.[86] In future laws and regulations, policy makers should place a greater emphasis on the norms of the mental health profession, such as the generally accepted standards of care,[87] and close the medical necessity loopholes that insurance companies use to avoid coverage.

Insurance companies can do their part by updating their reimbursement rates to mirror the norms and needs of the mental health profession, rather than using the same system used to reimburse medical and surgical services. For example, insurance companies could build reimbursement rates to allow doctors to spend more time with patients than the eleven minute requirement used for medical and surgical doctors.[88] Typically, psychiatric doctors diagnose a mental health condition through face-to-face interaction because the condition usually can only be discovered via interviews and trial-and-error with the medicine.[89] Thus, insurance company reimbursement rates need to be tailored to maximize the time the mental health provider can spend with the patient, which means streamlining the record keeping requirements and other administrative tasks to keep the doctor's schedule free.

Finally, further mental health legislation should require two things: (1) higher coverage for preventative mental health treatment so patients are encouraged to see a mental health provider before their condition spirals out of control and (2) higher reimbursement rates to mental health professionals. Ultimately, these steps will help address the twofold problem of funding for mental health profession and the shortage of professionals entering the field so patients can receive the mental health care they so desperately need.

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[84] FLA. STAT. § 394.455(36).
[85] *Wit*, 2019 WL 1033730, at *5–6.
[86] *Id.* at *17.
[87] *Id.* at *14–15.
[88] Levin, *supra* note 21. Insurance companies place high administrative demand on medical/surgical doctors and force them to bounce from patient to patient. *Id.*
[89] Schuyler, *supra* note 46.

V. CONCLUSION

American demand for mental health services is at unprecedented levels, but access to those services is becoming increasingly difficult because doctors and insurance companies are not working together. As discussed in Part II, Congress has passed three different laws that address mental health parity, but those collective laws have still left gaps in coverage that has prevented the industry from achieving true parity. Though the Affordable Care Act mandated mental health coverage by insurance plans, insurance companies have failed to adequately cover mental health services by limiting their network of providers,[90] maintaining poor reimbursement rates,[91] and refusing coverage through arbitrary standards such as medical necessity.[92] Similarly, doctors are switching to cash-only services and not accepting insurance, so patients without sufficient financial resources are unable to access care.[93] Even people in better financial condition are more likely to forego important preventative mental health care, because if they can't easily find a provider that accepts their insurance, then they are less likely to go in for a mental health check-up.[94] Thus, policy makers at the state and federal levels need to focus on solutions that entice doctors to accept insurance, encourage new professionals to enter the mental health profession, and prevent insurance companies from exploiting doctors with power of the purse tactics such as reimbursement rates. In theory, this will require a combined effort from the mental health industry, the insurance industry, and policy makers—after all, teamwork makes the dream work.

[90] Douglas et al., *supra* note 32, at 2–3.
[91] Petersen, *supra* note 49.
[92] *Wit*, 2019 WL 1033730, at *10.
[93] Levin, *supra* note 21; Patterson, *supra* note 49.
[94] Tovino, *supra* note 17, at 10. Though the ACA requires coverage of preventative services such as mental health counseling, the coverage is moot if there are no counselors that accept insurance. *Id.*