BEHAVIORAL HEALTH PARITY FOR CHILDREN

FIRST FOCUS ON CHILDREN

WHAT IS BEHAVIORAL HEALTH PARITY?

Treating mental health conditions and substance use disorders as equivalent to other health conditions in insurance plans is what is meant by "behavioral health parity." The term "behavioral health" is a phrase inclusive of both mental health and substance use disorder conditions. Parity does not consistently exist across the American health care system as it relates to behavioral health, although most people agree that behavioral health is an important and equally critical component of overall health.

WHAT A LACK OF PARITY MEANS TO CHILDREN AND FAMILIES

When a child or teenager has a behavioral health crisis (mental health issue, eating disorder, substance use disorder, etc.), a parent's first instinct is to seek immediate and appropriate care so their child can receive a timely, proper diagnosis and treatment. In other words, their response is exactly the same as if their teen had just broken their arm in a bike accident or experienced a seizure. Unfortunately, when children and teens experience a behavioral health crisis—even if they are covered by health insurance (private insurance or Medicaid)— help may *not* be on the way.

When behavioral health services do not have parity with other health care services, children and teens in crisis lack options for care and providers. Some common areas of concern and the implications of lack of parity include:

- **Network adequacy:** Even when a child has insurance, they may encounter outdated or severely limited provider networks, weeks— or months-long wait lists, or providers so overburdened that they are not accepting new patients. When these children cannot access home and community-based services in real time, they go without proper care and risk experiencing a crisis. At the point of crisis, a hospital emergency room may be the only viable option for the child or teen to receive immediate care— a route into the system that is traumatic for the child and family, chaotic, and costly.
- **Low reimbursement rates:** Many behavioral health providers are disincentivized to see insured patients because some insurance companies and Medicaid reimburse these services at low rates. Providers often opt out of insurance networks and provide services only to individuals who can afford to pay out-of-pocket. This practice can exclude large numbers of low-income and other children from accessing critical behavioral health care services.
- **Limit on number of visits:** Many insurance companies restrict the number of behavioral health visits they will cover, often limiting a patient to far fewer visits than needed. These restrictions can force children and their families into higher out-of-pocket spending or to abandon treatment before it is complete, which may result in unsuccessful outcomes.
- **Higher co-pays:** Children in need of treatment may also face higher co-pays for behavioral health services than for other health care services.
- **Prior authorization for in-patient care:** Insurance companies impose far more restrictions on prior authorization for in-patient behavioral health treatment than for other health care, forcing delays, paperwork and bureaucratic red tape. Children and teens experiencing a crisis may have to spend days in a hospital emergency room until they are authorized for in-patient care.

WE HAVE A PARITY LAW, SO WHY DO WE STILL HAVE PROBLEMS?

In 2008, Congress passed, and President George W. Bush signed into law, the Mental Health Parity and Equity Act (MHPAEA), which addresses the disparities between general and behavioral health care and seeks to create equal access to behavioral health services. Insurance companies, however, have skirted the universal benefits guaranteed by the MHPAEA law, and enforcement of the law is lacking, meaning no one, including children and youth, has achieved equitable access over the past 14 years. Even the 2010 passage of the Affordable Care Act did not force insurance companies to offer parity in behavioral health services, although it did include behavioral health services and treatment as one of the ten Essential Health Benefit requirements.

Many insurers design and apply their managed care requirements — such as prior authorization, step therapy, and requirements for providers to join an insurer's network — to be more restrictive for behavioral health conditions than for other health conditions. Such practices can delay or prevent needed care for children and youth in crisis.

The 2020 Consolidated Appropriations Act required insurers and health plans to perform comparative analyses across a range of criteria and report the results. In response to requests for information on practices including treatment plan requirements, benefits, preauthorization requirements, limits on telehealth, billing, pre-certification requirements and other critical areas, the companies returned incomplete answers and insufficient data that prevented reviewers from fully assessing parity compliance. Nevertheless, the 2022 MHPAEA Report to Congress from the Departments of Labor, Health and Human Services, and Treasury lays out numerous deficiencies on parity and compliance with the law. The bottom line: Group health plans consistently offer insufficient data and fail to adequately address violations, and the agencies charged with oversight have failed to ensure compliance.

During congressional mental health hearings in the spring of 2022, several lawmakers noted that the 2008 MHPAEA law would fix the parity problem, but that oversight agencies have not enforced it. They called for more resources and technical assistance to help state agencies and regulators oversee insurers that operate in their states.

THE PANDEMIC EXPOSED THE SEVERITY OF THE SITUATION

The COVID-19 pandemic only sharpened the focus on an existing behavioral health crisis among children and teens. The suicide rate among youth ages 10-24 has increased nearly 60% since 2007 and even before the pandemic, 12 – 20% of children under the age of 18 had experienced a mental health issue. In a December 2021 advisory, U. S. Surgeon General Vivek Murthy said children and teens in our country are experiencing a mental health crisis with rising rates of depression, suicide, and substance abuse. Up to one-in-five children ages 3-17 report a mental, emotional, developmental, or behavioral disorder. Approximately 360,000 teens call the National Suicide Prevention Lifeline each year. More than half of adults (53%) with children in their households say they are concerned about the mental state of their children.

PREVENTION AND EARLY INTERVENTION IS IMPORTANT

Prevention and upstream efforts to reduce stigma around mental health issues have proven critical to helping children and teens avoid crises. Half of all lifelong mental illness shows first signs before the age of 14, and 75% of lifelong mental illness begins before age 24. Making preventive services more available to children and teens and building their social and emotional awareness will strengthen their resilience and help prevent the onset of serious illness.

MOST CHILDREN AND TEENS GO WITHOUT TREATMENT

Early intervention and prevention are key to avoiding or postponing a crisis, yet more than 60% of children in the United States who experience a severe depressive episode do not receive treatment. Typically, 11 years pass between the onset of symptoms in a child or adolescent and the time they get treatment. Parents desperate to find care for a child in crisis have increasingly shown up at hospital emergency rooms because they offer the only opportunity to receive urgent professional care. Children should not wait days, months or even years for treatment and should not be forced into emergency rooms out of desperation and lack of community-based resources. Children with behavioral health issues should not have to suffer and wait for a crisis.

DISPARITIES CONTRIBUTE TO LESS ACCESS

While the pandemic has brought mental health challenges to children of all backgrounds, children of racial and ethnic minorities have been disproportionately affected. Mental health disparities exist depending on where you live, your race, your economic status, and other factors. Youth in rural and urban underserved areas struggle with a shortage of behavioral health providers. Rural youth are about twice as likely to die by suicide as youth in urban areas. Racial and ethnic minority youth experience higher rates of mental illness, but are less likely to receive care due to access barriers. Girls are more likely to be diagnosed with anxiety, depression or eating disorders while boys are more likely to die by suicide. One study found that 42% of LGBTQ youth had considered attempting suicide in the past year.

SOLUTIONS

Solving the multifaceted problem of achieving parity will require government, providers, group health plans, states, and other entities to work better together. Congress and the relevant agencies must strengthen and enforce the existing 2008 MHPAEA law, and must provide states with adequate support to oversee, monitor, and enforce parity at the state level. First Focus on Children supports lifting the voices of children and youth and empowering parents who face barriers in finding and paying for care for their children. Efforts to investigate consumer complaints about denials of services and/or network adequacy issues are important to children and families. Our ability to address the youth mental health crisis in this country hinges in part upon parity. Achieving parity will require:

- **Network adequacy**
- **Fair reimbursement rates**
- **Consumer empowerment and education**
- **Oversight of insurance companies**

Only when our nation's children and youth can access affordable, high-quality behavioral health services — a standard we apply to the rest of their health care — will we reduce their rates of anxiety, depression, suicide, and substance abuse and offer them a brighter, healthier future.

To learn more about how to address the youth mental health crisis, see our fact sheet.