improve mental health financing
strategies to improve children’s mental health financing

Effective financing systems for children’s mental health are essential to building an overall comprehensive system of care. Yet, there are numerous challenges and barriers, many of which impact not only financing and service delivery systems but children’s access to mental health services. These issues include:

- Limitations on coverage for mental health services in public and private health insurance systems
- Inadequate payment for mental health services, including preventive services, to primary care clinicians, mental health professionals, and other key professionals
- Billing and coding rules and regulations that impede the provision of mental health services by primary care clinicians and other types of clinicians
- Behavioral health care carve-outs in managed care plans that limit the ability of primary care clinicians to make direct referrals for mental health services, thereby creating access barriers to services for children and their families
- Lack of compensation for case management and care coordination efforts
- Time restrictions that limit the ability of primary care clinicians to adequately address mental health needs in children

Because the financing of children’s mental health services is complex, efforts to improve financing systems should involve strategies aimed at both the public and private sectors. While public and private health care systems typically operate separately, there are many areas of intersection that have implications for financing systems. Many children with mental health needs are served by both public (eg, Early Intervention and special education) and private (eg, health insurance) systems. Moreover, many primary care clinicians serve both publicly and privately insured children.

What Does This Mean for American Academy of Pediatrics Chapters?

Since public programs fund a substantial proportion of children’s mental health services, chapters may want to consider how they can improve the financing of children’s mental health services through the public system. A significant step to identifying realistic chapter strategies in this area is to first identify and consider the opportunities and barriers that state and community agencies experience in addressing this issue, which will be different for every state.

Every state is unique in its organization and delivery of children’s mental health services. Chapters may want to conduct an initial “environmental scan” to identify issues, including:

- The key state agencies with responsibilities for children’s mental health
- Where those agencies are located within the state government organizational structure
• The core children’s mental health goals and priorities for these agencies
• Any existing state initiatives (eg, state task forces, parity laws, and legislation) to address children’s mental health overall and, in particular, financing of mental health services

Gathering information on existing, planned, and even failed state initiatives can help inform chapter efforts and identification of strategies to improve financing of children’s mental health programs and services. Chapters may want to consider holding meetings with representatives from key state agencies and programs (eg, mental health, public health, and Medicaid) and with key child and family advocacy organizations in their state. These meetings can help further inform the environmental scan and identification of the areas that are most relevant, optimal, and timely for chapter involvement and work. Chapters also may want to convene a variety of stakeholders to address children’s mental health overall, including financing of programs and services. Strategies and considerations for convening key stakeholders in children’s mental health are included in other sections of this Chapter Action Kit.

What’s in a Name?
State and community children’s mental health initiatives are as varied as the systems that support them. In some states, early childhood development is a core priority and, while not officially called “children’s mental health,” has all the semblances of efforts to improve the overall children’s mental health system. “Social and emotional development” is another policy area being advanced by states, particularly state public health and education agencies.

Chapters may want to think broadly and consider the range of initiatives and programs that are related to children’s mental health—initiatives that, at first glance, might not seem focused on financing, but may have significant implications for the financing and delivery of children’s mental health services. A good example is the efforts in Illinois to address maternal depression (and its impact on young children) by providing Medicaid payment for maternal depression screening that is conducted by pediatricians as part of a well child visit.

Public and Private Payment of Mental Health Services
Chapters also may want to consider policy issues that are related to public and private payment of mental health services. To identify key payment issues, chapters may want to survey members or use a Hassle Factor Form to gain insight into payment barriers and challenges. (See Tools and Resources in this section for the Hassle Factor Form.)

Questions to consider in identifying payment issues include:

• What diagnoses (and related diagnostic codes) do private health insurance plans and public insurance programs (eg, Medicaid and SCHIP) pay for?
• What diagnostic codes are accepted by various public and private health insurance plans?
• Do private health insurance plans and Medicaid pay for primary care clinicians to treat mental health disorders (eg, depression, attention-deficit/hyperactivity disorder, and anxiety disorders) in children?
• Can specialists and mental health professionals get paid by public insurance programs and private health insurance plans?
Examples of policy changes that chapters could negotiate with payers include:

- Expand the number of mental health visits without a diagnosis that can be reimbursed by Medicaid.
- Empanel pediatrics with advanced mental health credentials on behavioral health carve-outs. (Chapters may want to consider advancing recommendations that begin with empanelling developmental/behavioral-boarded pediatrics.)
- Ensure that key primary care clinicians and mental health professionals (eg, licensed clinical psychologists and social workers, and nurses with specialized psychiatric training) are eligible to receive payment for assessment and treatment services under Medicaid.
- Expand the “Incident To” Rule† to pay mental health professionals under Medicaid.
- Establish a standard of mental health practice that requires exchange of information between mental health professionals and primary care clinicians.

**Strategies for Improving Financing of Children’s Mental Health Services**

Chapters may want to identify and consider a range of strategies for improving the public and private financing of children’s mental health services. These strategies include the following:

- Recommend maximizing the use of key federal and state program funds for children’s mental health and integrate multiple federal and state funding streams. (See Tools and Resources in this section for the American Academy of Pediatrics State Government Affairs Issue Brief: Mental Health.)
- Recommend that all parts of the children’s mental health system are adequately financed. (See Tools and Resources in this section for the National Conference of State Legislators Brief: Children and Mental Health Parity, and Collecting Information for Chapter Advocacy: Mental Health Public and Private Payer Matrix.)
- Recommend improved coordination of financing among the key state agencies and child-serving programs (eg, mental health, substance abuse prevention, public health, Medicaid/SCHIP, child welfare, juvenile justice, education, and Early Intervention) with responsibilities for children’s mental health.
- Recommend blending or braiding of state programmatic funds to provide more services and eliminate duplication of services. Blended funding involves combining funding from multiple funding sources into a single “pot” of dollars that can be used to fund services. Braided funding entails using multiple sources of funds to pay for services, while maintaining tracking and accountability of these funds for administrative purposes. Given federal rules and regulations for use of funds, braided funding is often seen as a more attractive and simpler strategy for state agencies. Vermont has used a braided funding system composed of federal child welfare, juvenile justice, mental health, and special education funds.

†The Incident To Rule refers to services provided by physician extenders (eg, clinical psychologists, clinical social workers, nurse practitioners, and nurses) under the direct supervision of a physician that are an integral, although incidental part of a physician’s professional service in the course of diagnoses or treatment of an injury or illness. Such services may be billed as though personally rendered by the physician, provided all criteria for billing incident to are met.
to support programs for children and adolescents with serious emotional disturbances.3

- Recommend full implementation of Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program to ensure that eligible children receive the mental health screens and services to which they are entitled.
- Advocate for full mental health parity or equal coverage laws.
- Recommend increasing investments in prevention and early intervention programs and services to prevent mental health issues from developing into more serious problems. These investments may come from existing programmatic funding sources, such as the Title V Maternal and Child Health (MCH) Services Block Grant, which have flexibility in how funds are used. Idaho, Illinois, Michigan, Minnesota, North Carolina, Rhode Island, and Washington are some of the states that have implemented initiatives to improve access to children’s mental health services and/or the overall children’s mental health system.
- Develop and/or utilize an existing Pediatric Council, which meets regularly with managed care organization representatives, to discuss issues of quality care, including inadequate communications between clinicians, system issues, and barriers to mental health care (eg, behavioral health care carve-outs). Twenty-four chapters have established these councils. The Massachusetts Chapter Pediatric Council has been in existence the longest of these councils, and has been successful in changing the policies and practices of managed care companies as they relate to children’s health care. Although fees cannot be discussed during these meetings, it is acceptable to discuss the lack of communication and resulting problems due to behavioral health care carve-outs. (See the Tools and Resources section for the Chapter Pediatric Councils Overview.)
- Initiate discussions with private insurance companies through Pediatric Councils to advocate for enhanced coverage of children’s mental health services. (See the Tools and Resources section for Pediatric Mental Health Payment Strategies Targeting Payers, Pediatric Mental Health Coverage Template Letter and Survey, and Hassle Factor Form.)
- Initiate discussions with benefits managers in large businesses and companies to educate them about the benefits of comprehensive coverage of mental health services for the children of their employees.

References
Resources for Further Information
The AAP Division of State Government Affairs. Available at: http://www.aap.org/advocacy/stgov.htm Accessed December 1, 2006

The AAP Division of Health Care Finance and Quality Improvement. Available at: http://www.aap.org/visit/divfinprac2.htm Accessed December 4, 2007


Accessed January 17, 2007

strategies to improve children’s mental health financing tools and resources

strategies for system change in children’s mental health: a chapter action kit

How Children’s Mental Health Services Are Financed Fact Sheet
This issue brief provides an overall description of how children’s mental health services are financed at the federal, state, and community levels.

Chapter Pediatric Councils Overview
This resource provides an overview of the purpose of chapter pediatric councils and examples of changes in mental health coverage and policies that result from the work of these councils. It includes a matrix of Current Procedural Terminology (CPT) codes that are recognized by health insurance carriers, developed by the North Carolina chapter.

Hassle Factor Form
This tool may be completed online with the American Academy of Pediatrics (AAP) to report insurance, administrative, and claims processing concerns, including settlement disputes that have been filed by pediatric practices. It is available on the AAP Member Center site and is intended to be submitted electronically.

Pediatric Mental Health Coverage Template Letter and Survey
This tool is a sample survey and cover letter for obtaining information from health insurance carriers on the scope of coverage for pediatric mental health.

Collecting Information for Chapter Advocacy: Mental Health Public and Private Payer Matrix
This tool is a template for chapters and their pediatric councils to gather information about public and private health plans in the state regarding coverage policies (e.g., coverage services, and payment authorization policies) for mental health services.

Pediatric Mental Health Payment Strategies Targeting Payers
This resource provides strategies for pediatric practices to use in promoting coverage of mental health care, and in managing carrier denials and contractual issues related to pediatric mental health.

American Academy of Pediatrics State Government Affairs Issue Brief: Child and Adolescent Mental Health
This issue brief provides an overview of child and adolescent mental health issues for use by chapters when communicating with legislators or other public officials.
National Conference of State Legislatures Brief: Children and Mental Health Parity (May 2005)
Reprinted with permission from the National Conference of State Legislatures. This Policy Matters resource from the National Conference of State Legislatures (NCSL) is included for its broad discussion of mental health parity and public policy in the states. Because it was published in 2005, it includes information on state laws that is out of date. For more up to date information about mental health parity laws and other current state policy trends, please consult the Child and Adolescent Mental Health Issue Brief from the AAP Division of State Government Affairs located in this section.
how children’s mental health services are financed fact sheet

strategies for system change in children’s mental health: a chapter action kit

Children’s mental health services are financed through an extensive patchwork of public and private funding sources at the federal, state, and community levels. These sources include public health care coverage (e.g., Medicaid and the State Children’s Health Insurance Program), and other federal programs (e.g., the Comprehensive Community Mental Health Services for Children and Their Families Program* † and Early Intervention), private health insurance, state and county funds, and private foundations. Of all mental health services that are provided to adults and children, more than half (53%) are paid for by public sources.¹ In fact, public funding sources pay for a disproportionate share of mental health services for children as compared to private health insurance.

Financing of children’s mental health services is largely aligned with the presence of a diagnosable mental health disorder. Consequently, children who have a mental health problem but lack a full mental health diagnosis often experience limited or no access to mental health services. In addition, efforts to provide care for mild and moderate mental health problems can be impeded. A national study of children and adolescents aged 9 to 17 years revealed that nearly 21% had a mental health problem. Almost half of the child/adolescent population had some treatment, while the remainder received no mental health treatment in any sector of the health care system. Of the children with mental health problems, many did not meet the full criteria for a mental disorder diagnosis.¹

Historically, mental health services for children have been highly fragmented, underfunded, and often duplicated. Where resources do exist, funds are largely targeted to children with serious emotional disorders with few resources available for prevention and early intervention efforts, and care for children with mild to moderate mental health issues. As a result, families must often navigate a complex system of private and public services and programs to obtain services for their child—services that may not be paid for by private health insurance or reimbursable by public program funds.

Mental Health Care Expenditures for Children²

- Children account for approximately 7% of all mental health expenditures.
- The cost of treating children and adolescents is nearly $12 billion with most funds spent on outpatient care.

*Federal Comprehensive Community Mental Health Services for Children and Their Families Program funds are administered by the Substance Abuse and Mental Health Services Administration and available to States, communities, Territories, and Indian tribes/tribal organizations to build community capacity, provide treatment services, and involve families in serving children and adolescents (under 22 years of age) with diagnosable serious emotional, behavioral, or mental disorders and who require services from multiple agencies.
• Among children aged 1 to 17 years, adolescents (aged 12 to 17 years) account for 60% of the total costs for mental health services yet make up only 35% of the child population.
• Children aged 6 to 11 years account for 35% of the mental health costs and preschoolers (aged 1 to 5 years) account for 5% of these costs.

Numerous Federal Programs Support Children’s Mental Health
The highly fragmented nature of children’s mental health services is largely due to the myriad public and private systems that serve children and their families. These public systems include primary care, public health, mental health, child care, child welfare, education, substance abuse prevention, and juvenile justice. Each of these systems receives federal funding that stipulates its own set of rules and regulations, target populations, and eligibility categories for services. In turn, these federal dollars usually are administered by numerous state agencies (eg, Medicaid, education, and public health). As a result, states and communities often struggle to integrate programs and services, and blend complex federal, state, and community funding streams into a seamless system of care for children. Building a comprehensive system of children’s mental health services requires an understanding of these numerous systems and the programs that fund them, collaboration among key state agencies, and a willingness on the part of state agencies to blend complex funding streams.

Every State Has a Designated State Mental Health Authority
Historically, the financing and delivery of public mental health services has been a state responsibility. Most state spending comes from general revenue funds, state Medicaid contributions, and other state funds (eg, private foundations). Every state has a designated state mental health authority—a state mental health agency or a mental health division that is located within a larger state health agency—as required by the federal Community Mental Health Services (CMHS) Block Grant Program.

The CMHS Block Grant Program, administered by the Substance Abuse and Mental Health Services Administration, is the largest federal funding contribution dedicated to improving mental health service systems for adults and children nationwide. It provides funds to states to establish or expand a comprehensive community-based system for providing mental health services to adults with serious mental illness and children with serious emotional disturbances (SED), as outlined in a State Mental Health Plan. Among numerous requirements, states must establish a State Mental Health Planning Council, composed of consumers, family members, clinicians, and others, to review their State Mental Health Plan. In addition, states are required to set aside a portion of CMHS Block Grant funds for children and adolescents with SED.

Medicaid Pays for the Bulk of Mental Health Services in States
While the CMHS Block Grant is the largest source of federal funds for mental health services, Medicaid pays for the bulk of mental health services in states—half of state and local mental health spending. Eligible children are entitled to any authorized service under Medicaid. Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requires that states cover any service that is medically necessary to

†State Planning Council activities and duties include reviewing plans and submitting any recommendations for modification to the state, serving as an advocate for adults and children with mental illnesses, and monitoring, reviewing, and evaluating the allocation and adequacy of mental health services.
"correct or ameliorate defects and physical and mental illnesses and conditions, regardless of whether the service or item is covered under the state Medicaid program." Mental health screens can be the result of a formal health checkup or screen for a potential mental health problem.

Because of the Medicaid entitlement and breadth of the Medicaid EPSDT requirement, coverage of mental health services under Medicaid is more comprehensive than private health insurance. In spite of the protections afforded eligible children under Medicaid, there is wide variability in states’ implementation of the EPSDT benefit, leaving many children without the mental health screens and treatment that they are entitled to under federal law. States define medically necessary services in different ways or not at all, and do not always specify required mental health services with Medicaid contracting agencies, leaving decisions about which mental health services to cover up to health plans.

The State Children’s Health Insurance Program (SCHIP) covers low-income children whose family incomes are too high to qualify them for Medicaid but who lack private health insurance. States can choose to expand Medicaid, create a separate SCHIP program, or develop a combination program. While SCHIP is an important source of health care coverage for low-income children, children with mental health needs can experience challenges in accessing mental health and substance abuse services, particularly in states with separate SCHIP programs. For these states, coverage of mental health services may be less generous than Medicaid coverage since the SCHIP statute only requires that they provide a mental health benefit that is 75% of the value of the benefit in the benchmark plan.

<table>
<thead>
<tr>
<th>Children’s Mental Health Services Covered by Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mental health screening and assessment</td>
</tr>
<tr>
<td>• Inpatient hospital care, residential treatment centers, or group homes</td>
</tr>
<tr>
<td>• Clinic services by a physician or under a physician’s direction</td>
</tr>
<tr>
<td>• Outpatient hospital services</td>
</tr>
<tr>
<td>• Physician services and services by other licensed professionals</td>
</tr>
<tr>
<td>• Prescription drugs</td>
</tr>
<tr>
<td>• Rehabilitation services</td>
</tr>
<tr>
<td>• Targeted case management (eg, activities to connect children with mental health needs to services)</td>
</tr>
<tr>
<td>• Home and community-based services (versus care in an institution), in states with federal Medicaid waivers</td>
</tr>
</tbody>
</table>

Children’s mental health programs and services are supported by numerous other federal programs in addition to those outlined above. These programs include:

‡See the resources, Funding Early Childhood Mental Health Services and Supports, and Mix and Match: Using Federal Programs to Support Interagency Systems of Care for Children with Mental Health Needs for listings of federal programs that support children’s mental health services.
• Early Intervention (Part C of the Individuals with Disabilities Education Act)
• Developmental Disabilities
• The Title V Maternal and Child Health Services Block Grant
• The Social Services Block Grant, the Child Care Block Grant
• The Juvenile Justice and Delinquency Prevention Act
• Federal funds for foster care, special education, and child welfare

How and whether states use these funds to support a comprehensive children's mental health system of prevention, early intervention, and treatment varies significantly by state.

Private Insurance Pays for Nearly Half of Children's Mental Health Services Yet Access and Services Are Limited

Even though 70% of children are privately insured, private health insurance pays for less than half of the costs for children's mental health services. As previously mentioned, private health insurance coverage of mental health services is far less generous than public insurance coverage. Parity of mental health benefits—requirements that insurers provide the same level of mental health service coverage as that of physical health—is seen as a key strategy for increasing access to mental health services for children and adults. (See the Tools and Resources in this section, Pediatric Mental Health Payment Strategies Targeting Payers, for strategies that pediatric practices can use in promoting coverage of mental health care and in managing carrier denials and contractual issues that are related to pediatric mental health.)

Currently, 46 states have some type of enacted mental health parity law, yet these laws vary considerably. Many are not considered full parity because they allow discrepancies in the level of benefits provided between mental illnesses and physical illnesses. Efforts to enact full parity legislation at the federal level have been met with resistance from private insurance companies and other groups that are concerned about increases in insurance costs. The federal Mental Health Parity Act of 1996, which was extended through 2002 after expiring in 2001, did not require that insurers offer mental health benefits, but stated that, if mental health benefits were offered, they must be equal to the annual or lifetime limits offered for physical care. Evidence indicates that the impact of parity laws on increases in health care costs is minimal. (See the State Government Affairs Issue Brief “Child and Adolescent Mental Health” included in this Chapter Action Kit for more information on state parity laws.)

Conclusion

Thanks to key national reports, such as Neurons to Neighborhoods and the Surgeon General’s Report on Children’s Mental Health, states and communities are increasingly recognizing the need to improve how children’s mental health services are financed and delivered. Consequently, many states and communities have implemented new initiatives, programs, and policy changes to address the widespread recognition that children’s mental health is as important to their overall health and well-being as their physical health. Many of these initiatives include attention to improvements in how children’s mental health services are financed. Chapters may want to identify and consider a range of strategies for advancing and improving both the public and private financing of children’s mental health services. (See the Strategies to Improve Mental Health Financing in this section for a list of chapter strategies.)
References


6. 42 USC §1396d(a)


Resources for Further Information


Pediatric councils are groups that are formed to foster dialogue between pediatricians and insurance plan administrators. The American Academy of Pediatrics supports chapter development of pediatric councils as forums to discuss concerns about policies and administrative procedures that affect coverage, access, and quality. Chapters have reported that pediatric councils facilitate communication and lay the groundwork for successful problem solving with payers.

Following are some examples of changes in mental health coverage and policies that resulted from the work of chapters and pediatric councils:

- **Massachusetts**: Carriers will cover annual developmental screening.
- **Pennsylvania**: Most insurers recognize mental health codes.
- **Texas**: BlueCross BlueShield of Texas will now pay separately for developmental screening ([Current Procedural Terminology [CPT] code 96110](#)), whereas previously it bundled this with the evaluation and management (E/M) service.
- **New Jersey**: Many of the fee-for-service plans pay for mental health services by pediatricians; capitated plans don't "carve out" mental health.
- **New York**: A group practice in Rochester, NY, met with the regional BlueCross medical director and presented its case on the work-up for depression, which included a comprehensive review of family and social history, as well as many evaluation tools. Negotiations resulted in payment of the initial depression consult as a 99215, with subsequent follow-up at the 99214-level.
- **Ohio**: The Chapter joined an interdisciplinary Coalition for Healthy Communities to support passage of Mental Health Parity in the state.
- **Rhode Island**: Mental health was discussed at the June 2006 Rhode Island pediatric council meeting. Recently, BlueCross BlueShield of Rhode Island agreed to reimburse 99610 for developmental screening at well child visits.
- **Wisconsin**: The Wisconsin Council advocated with Humana’s regional medical director on pediatric mental health as an access issue. Humana agreed to pay pediatricians for managing common mental health conditions, such as attention-deficit/hyperactivity disorder, rather than paying only the less available child psychiatrists, often in carve-out contracts, for similar services.
- **North Carolina**: The North Carolina Council developed a matrix of CPT codes recognized by carriers. (See the ADD/ADHD and Coding: Recognition of CPT codes by Payer that follows.)

**Pediatric Council Start-up Kit**

A Pediatric Council Start-up Kit was developed based on experiences of chapters with pediatric councils and is intended to share information on starting and maintaining pediatric councils. The Pediatric Council Start-up Kit can be accessed on the AAP Member Center at: [http://www.aap.org/moc/reimburse/privatesector.htm#pediatriccouncils](http://www.aap.org/moc/reimburse/privatesector.htm#pediatriccouncils).

For more information, please contact Lou Terranova at lterranova@aap.org.
Pediatricians and Managed Care Directors in North Carolina understand that there has been much confusion around coding for ADD/ADHD. We have pulled together some information to help you understand when to use certain CPT codes when caring for children with behavioral health issues, specifically ADD/ADHD. Additionally, we have asked some of the larger health plans in North Carolina to see if they reimburse for these codes. The following information is the result of our work over the past 6 months.

**COMMONLY USED CODES IN BEHAVIORAL HEALTH**

- **99212-5.** Evaluation and Management (E&M) office visit, established patient, levels 2-5. *(face-to-face time required)*

- **99202-5.** Evaluation and Management (E&M) office visit, new patient, level 2-5. *(face-to-face time required)*

- **99241-5.** Consultation office visit, new or established. *(face-to-face time required; requires referral from a teacher/psychologist and a return follow-up letter/phone call to the referral source)*

- **90887.** Interpretation or explanation of results of psychiatric, other medical exam to family or advising them how to assist patient *(face-to-face not required)*

- **99354.** Prolonged physician service in the office requiring face to face time beyond usual service, 1st hour *(face-to-face required)*

- **99358.** Prolonged E&M service before and/or after direct patient care (for example, review of extensive records and tests), 1st hour *(face-to-face not required)*

- **99361.** Medical conference by a physician with interdisciplinary team of health professionals, approximately 30 minutes *(team interaction)*

- **99371.** Telephone calls by a physician to a patient or for consultation or medical management or coordinating medical management with other health care professionals *(face-to-face not required)*

Please note the codes that require face-to-face contact and the codes that do not require face-to-face contact. Please note the difference between codes 99354, requiring face-to-face contact for at least 1 hour beyond the usual 20-30 minute appointment, and 99358,
Also, please remember that E/M level of service codes reflect complexity rather than time unless greater than 50% is spent in counseling. When this is the case, the following time limits apply:

<table>
<thead>
<tr>
<th>CODE NEW</th>
<th>TIME(min)</th>
<th>CODE ESTAB</th>
<th>TIME(min)</th>
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<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>99211</td>
<td>5</td>
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<td>99202</td>
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<td>99212</td>
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<tr>
<td>99205</td>
<td>60</td>
<td>99215</td>
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Below is a matrix of these codes and 5 NC health plans, providing a synopsis of payer recognition of these codes. *(This should be used as a general guideline and may change from time to time. This information is correct as of October 2001):*

<table>
<thead>
<tr>
<th>CPT code</th>
<th>BCBSNC†</th>
<th>CIGNA</th>
<th>United</th>
<th>Partners</th>
<th>Aetna</th>
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<tr>
<td>99212-5</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>99202-5</td>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>99241-5</td>
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<td>90887</td>
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<td>Y</td>
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<td>N</td>
<td>Y</td>
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<tr>
<td>99354</td>
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<td>99358</td>
<td>Y</td>
<td>Y</td>
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<td>Y</td>
<td>N</td>
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<td>99361</td>
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<td>N</td>
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<tr>
<td>99371</td>
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</table>

All 5 insurers will pay for the standard E/M codes. When the encounter involves review of medical records/tests, interpretation/explanation of psychiatric or other medical exams with advice, and telephone calls before or after the visit (all codes not requiring face to face contact), please consult the matrix for recognition by payer. Seldom will the encounter involve enough direct patient time to satisfy CPT code 99354. If a patient requires a medical conference with an interdisciplinary team, consult the matrix for recognition by payer.

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* Codes must be supported by written documentation in order to justify payment. Please use the current CPT book as a guide to know how to code for all services. A pediatric-specific version of most commonly used codes can by obtained by calling the AAP or through their website at [www.aap.org](http://www.aap.org).

† Benefits are determined when the claim is processed and the claim is subject to member and provider contractual limitations and exclusions and subscriber eligibility. In addition, medical records may be requested and reviewed for documentation. Consultation codes should not be billed for established patients. Using the proper level of Evaluation and Management code, supplemented, if necessary by codes for prolonged physician services and/or medical conferences should permit appropriate payment.
HASSLE FACTOR FORM

The online Hassle Factor Form may be completed online to report insurance administrative and claims processing concerns including settlement disputes that you may have filed (see Settlement Disputes below for additional information). The information provided will be used to assist the AAP and chapters in identifying trends and facilitating public and private sector advocacy related to health plans.

Please note that completion of the following form is for data collection purposes only; information on hassles will be available to the national AAP and your chapter. **You will not receive a reply when completing the Hassle Factor Form.**

By collecting data on issues pediatricians have with third party payers, the AAP at the national and chapter levels will be better able to identify common areas of concern and facilitate dialogue with payers. Please complete one form per carrier.

**Proceed to the online Hassle Factor Form**

Should you require additional assistance on a particular coding or health plan coverage issue, contact your chapter or the AAP Coding Hotline at AAPCodingHotline@aap.org or 800/433-9016 ext 4022.

**Settlement Disputes:**

As a result of lawsuits brought against the major health plan carriers, some carriers have agreed to settlements that should benefit physicians. Settlements with Aetna and CIGNA have recently been finalized and one of the agreed upon terms is a process for physicians to file disputes with an external entity. Pediatricians are encouraged to file a dispute with the carrier(s) should there be a violation of the billing, medical necessity or settlement terms by accessing the forms on www.hmosettlements.com and then report any disputes that they file against Aetna, CIGNA and any other carriers by completing the Hassle Factor Form. Please note that the pediatric practice must file the dispute themselves - the AAP will not file a dispute. Completing the Hassle Factor Form is a way to notify the AAP that your practice has filed a dispute.

For information about the settlements see www.hmosettlements.com or the AAP MOC, private sector advocacy page link to managed care litigation.

See Form Below
**HASSE FACTOR FORM**

Please complete each section of this form.

**SECTION A: General Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name:</td>
<td></td>
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<tr>
<td>First Name:</td>
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<tr>
<td>Middle Name:</td>
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<td>Last Name:</td>
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<td>Subspecialty:</td>
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<td>AAP Member ID:</td>
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<td>Practice City:</td>
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<td>State:</td>
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<td>Practice Chapter:</td>
<td></td>
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<tr>
<td>Practice Type:</td>
<td></td>
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<tr>
<td>Person completing this form:</td>
<td></td>
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<tr>
<td>(If other than the physician identified above)</td>
<td></td>
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<tr>
<td>First Name:</td>
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<td>Middle Name:</td>
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<tr>
<td>Last Name:</td>
<td></td>
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<tr>
<td>Title:</td>
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</tbody>
</table>

**SECTION B:**

Please check all that apply and briefly describe problems on the next section (Section C). If provided examples do not describe your hassle, please check "Other Problem Not Listed," and detail on the next section (Section C).

**Administration**

- Calls not returned
- Claim/appeal lost by organization
- Credentialing delay/problems
- Excessive wait on telephone
- Failure to notify enrollees of denied services or failure to do so in a timely manner
- Grievance procedure problems
- Inaccurate data entry following clean claim
- Insufficient pediatric subspecialists in the network
- Medical records request problem
- Numerous calls for single claim
- Organization missing supporting documents
- Uncustomary request for patient information

**Payment Processing**

- Related to a specific CPT, ICD-9-CM, HCPCS Level II code
Specify the code [ ] CPT [ ] ICD-9-CM [ ] HCPCS

- Denial of payment
- Reduction of payment
- Recording of billed services (bundling, downcoding, etc.)
- Payment incorrect as per contract
- Late payment problem(s)
- Failure to follow CPT guidelines
- Non-recognition of modifiers
- Changing units of service

**Claims Adjudication**

- Denial of preauthorization (specify whether hospital or other)
  - [ ] Hospital  [ ] Other (If 'Other' please specify)
- Excessive delay in processing claims
- Excessive denials of referral
- Excessive emergency room service denial
- Excessive mental health service denial
- Excessive operative report requests
- Excessive prepayment or postpayment review
- Excessive requests for medical necessity review
- Lack of clear communication on EOB, written communications
- Length of stay dispute

**Contractual Issues**
(based on reviewing your managed care contract)

- Lab tests cannot be performed at preferred location
- Reimbursement denied due to carve out provisions
- Fee schedule not provided or excessive delay in obtaining it
- Managed care formulary
- Uncompensated for language interpretation

- Other problem not listed (Briefly Describe in Section C)

**SECTION C:**

Name of carrier with whom the hassle is related: (REQUIRED)
HASSE Factor FORM

Please complete this remaining section of the form.

SECTION D:
DISPUTES FILED AS PART OF LITIGATION SETTLEMENTS
Since you identified a carrier that is involved in the managed care litigation and has agreed as part of the settlement to the dispute process, please respond to the following: (for information on the settlements, see www.hmosettlements.com)

Have you filed a Dispute about this issue? ☐ Yes ☐ No
If yes, is the dispute related to (check all that apply)
☐ Billing dispute
☐ Compliance with terms of settlement dispute
☐ Medical necessity dispute

Please note that completion of the Hassle Factor Form does not constitute filing a dispute as part of the settlement. Pediatric practices must file the settlement dispute as the AAP does not submit the settlement dispute.
Date

Dear Medical Director:

The American Academy of Pediatrics __________ Chapter is addressing the issue of pediatric mental health care. One area of interest is the level of benefits coverage available to children covered under private health plans.

Attached is a brief survey on the extent of coverage for pediatric mental health services. Please note that data are not being collected on fees paid or charged. The intent is to obtain a perspective on the scope of benefits for pediatric mental health care. It is understood that health plan coverage may vary based on the scope of benefits purchased by the employer or family. However, we hope to obtain a better understanding of mental health services that are covered under the standard health plan or as part of carrier policy.

Please let me know if you have any questions or need additional information. Your response by __________ would be greatly appreciated.

Sincerely,
Pediatric Mental Health Coverage Survey

1. Does the plan’s mental health professional network include:
   - Primary care clinician?  Yes ☐ No ☐
   - Developmental pediatricians?  Yes ☐ No ☐

2. Do you have standards concerning exchange of information between the plans’ credentialed mental health professional and their patients’ primary care clinician?  Yes ☐ No ☐

   If yes, do these standards include (please check all that apply)
   - ☐ Verbal or written communication of a presumptive diagnosis and plan of treatment within 3 days of completion of assessment of the patient?
   - ☐ Ongoing progress reports at least monthly?
   - ☐ Description of the discharge plan when the mental health professional terminates the treatment?
   - ☐ Other? (Please list)

3. Under the standard carrier contract with pediatricians, will your claims systems process and pay claims submitted by pediatricians using the following Current Procedural Terminology (CPT) codes for evaluation and treatment of behavioral and mental health conditions?

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ 99201/</td>
<td>Office or other outpatient services, new patient. Problem-focused history and</td>
</tr>
<tr>
<td>99202/99203/</td>
<td>examination</td>
</tr>
<tr>
<td>99204/99205</td>
<td></td>
</tr>
<tr>
<td>Yes ☐ 99212/</td>
<td>Office or other outpatient services, established patient</td>
</tr>
<tr>
<td>99213/99214/99215</td>
<td></td>
</tr>
<tr>
<td>Yes ☐ 99241/</td>
<td>Office or other outpatient consultations.</td>
</tr>
<tr>
<td>99242/99243/</td>
<td></td>
</tr>
<tr>
<td>Yes ☐ 99354/</td>
<td>Prolonged physician service with face-to-face patient contact; outpatient</td>
</tr>
<tr>
<td>99355</td>
<td></td>
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<tr>
<td>Yes ☐ 99371/</td>
<td>Use to report telephone calls made by the physician to patient/parent, or for</td>
</tr>
<tr>
<td>99372/99373</td>
<td>consultation or medical management, or for coordinating medical management with</td>
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<tr>
<td></td>
<td>other health care professionals.</td>
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<tr>
<td>Yes ☐ 96110</td>
<td>Developmental testing, limited with interpretation and report</td>
</tr>
<tr>
<td>Yes ☐ 96111</td>
<td>Developmental testing, extended with interpretation and report, per hour</td>
</tr>
</tbody>
</table>

4. Under the standard carrier contract with pediatricians, will your claims systems process and pay on claims submitted by pediatricians treating behavioral and mental health conditions using the International Classification of Diseases, 9th Revision, Diagnostic Manual (ICD-9-DM) codes listed on the following page.  Yes ☐ No ☐

   (NOTE: The chapter would determine which diagnoses they are interested in learning about coverage.) Thank you for providing this information.

7-24
This matrix serves as a template for chapters and their pediatric councils to gather information about public and private health plans in the state, regarding coverage policies for mental health services. It asks about what services are covered, which health care clinicians can provide them, and payment and authorization policies. Chapters and their pediatric councils are encouraged to gather this information on all major plans in the state and use the matrix as a way to compare the plans. The matrix can help identify gaps in services that chapters can address in their discussions with health plans.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>State Medicaid</th>
<th>Managed Care (HMO)</th>
<th>Self-insured Plan (PPO)</th>
<th>Other Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are patients authorized to receive outpatient mental health services?</td>
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<tr>
<td>Primary care clinician referral</td>
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<td>sufficient</td>
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<tr>
<td>Primary care clinician obtains authorization</td>
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<td>Phone</td>
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<td>Patient/family obtains authorization</td>
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<td>Phone</td>
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<td>Other, please specify:</td>
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<tr>
<td>Plan Name</td>
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<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
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<tr>
<td>Does the plan pay primary care clinicians for outpatient mental health/substance abuse services?</td>
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<tr>
<td>Yes</td>
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<td>No</td>
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<tr>
<td>Is the plan limited to certain diagnostic codes?</td>
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<td>Yes</td>
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<td>No</td>
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<td>If yes, does it permit ICD-9 deferred diagnoses codes?</td>
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<td>Yes</td>
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<tr>
<td>How many visits can a patient receive after initial authorization?</td>
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<tr>
<td>Which mental health/substance abuse professionals does the plan reimburse for outpatient mental health/substance abuse services?</td>
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<td>Are they restricted to certain employment arrangements?</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>If yes, specify arrangements.</td>
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<tr>
<td>Plan Name</td>
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<tr>
<td>Does the plan allow primary care clinicians to bill “incident to” for mental health/substance use/abuse services delivered by a mental health professional in the primary care clinicians employ?</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>If yes, which disciplines (eg, child and adolescent psychiatrist or licensed clinical social worker)?</td>
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<tr>
<td>Are there mental health/substance use/abuse providers with pediatric expertise available in all geographic regions of the state served by the plan(s)?</td>
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<tr>
<td>Yes</td>
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<td>No</td>
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<tr>
<td>Are children and adolescents matched with mental health/substance use/abuse providers who have pediatric expertise?</td>
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<td>Yes</td>
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<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Does the plan have standards requiring mental health professional to communicate with primary care clinicians?</td>
<td></td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>With reference to the following Evidence-based Child and Adolescent Psychosocial Interventions, which does the plan pay for? (please check all that apply):</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cognitive behavioral therapy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavior therapy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Parent training</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Educational support</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Interpersonal therapy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Family therapy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Applied behavioral analysis</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other, please specify:</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Does the plan have mental health professionals qualified to perform the evidence-based therapies itemized above?</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>How many child psychologists per covered lives?</td>
<td>7-28</td>
<td>7-28</td>
<td>7-28</td>
<td>7-28</td>
</tr>
<tr>
<td>Plan Name</td>
<td>State Medicaid</td>
<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
<td>Other Plan</td>
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<tr>
<td>How many child and adolescent psychiatrists per covered lives?</td>
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<td>How many licensed clinical social workers per covered lives?</td>
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<tr>
<td>How many other child and adolescent mental health professionals per covered lives?</td>
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<tr>
<td>How many developmental and behavioral subspecialists per covered lives?</td>
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<tr>
<td>Does your plan credential developmental and behavioral subspecialists as mental health professionals?</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Please explain:</td>
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<tr>
<td>In each state, what percentage of the plan’s major products covers mental health benefits?</td>
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</tr>
<tr>
<td>Does the plan use an ambulatory managed behavioral health care company (eg, carve-out)?</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Name</td>
<td>State Medicaid</td>
<td>Managed Care (HMO)</td>
<td>Self-insured Plan (PPO)</td>
<td>Other Plan</td>
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<tr>
<td>If yes, which one(s)?</td>
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<tr>
<td>Which of the plans has the best mental health benefits?</td>
<td></td>
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</tr>
<tr>
<td>What percentage of children in the state participate in this plan?</td>
<td></td>
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</tr>
<tr>
<td>Does the plan have mental health co-pays and deductibles that differ from physical health co-pays and deductibles?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, please specify:</td>
<td></td>
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</tbody>
</table>
Carriers may have health plans that do not cover mental health services or that “carve out” mental health benefits completely or partially (e.g., create a separate set of rules, providers, and authorization procedures for mental health). They may offer employers plans that diminish or exclude mental health benefits. Following are strategies for pediatric practices to use in promoting coverage of mental health care and in managing carrier denials and contractual issues related to pediatric mental health. Should a practice have several health plan contracts, these strategies may be concentrated on the top (3-5) major plans with which the practice works.

The key is to determine the level of coverage by the health plan for pediatric mental health services. Health insurance carriers have multiple health plans and coverage may vary from plan to plan.

Dealing With Mental Health Carve-outs
Some carriers may carve out mental health services from the medical provider network, assigning them to a smaller mental health specialty network or a disease management program. Employers or families may select a health plan that has limited mental health benefits.

- The pediatric practice should contact the carrier to determine the nature of the carve-out and the degree to which coverage and payment are available for mental health services.
- Pediatricians and their staff should be aware of health plan enrollment periods and be available to advise their patients’ families on coverage issues. Often, families make decisions on health plan selection on the basis of premium expense, without consideration of other out-of-pocket expenses, such as deductibles, co-payments, and level of coverage.
- Advocate for coverage and payment of pediatric mental health services, particularly during the contract renewal period.
- Frame your position on how lack of coverage impacts quality of care, cost effectiveness, and patient satisfaction. Carriers are very conscious of quality issues, expenses and efficiency, and their market share.
- Provide reassurance that increasing access to outpatient mental health services creates cost savings in areas such as emergency room utilization and hospitalization. Studies have shown that per member/per month mental health costs do not increase significantly when mental health benefits are at parity with medical benefits.
- Highlight cases in which your practice has provided high-quality, cost-effective mental health services.
Joining the Network
While most behavioral health plans are limited to mental health specialists, there is a movement by health plans to merge mental health and medical benefits and to expand their network. Developmental-behavioral pediatricians, in particular, may want to participate as mental health professionals.

- Check with the carrier to determine whether the provider panel is open to pediatricians and what credentialing criteria may be in place.
- See whether the carrier provides training or online programs that enable prospective providers to join the network.
- Determine whether access to mental health specialty care is an issue for the carrier, and use this to negotiate with the carrier to serve as a mental health professional. Carriers may realize that pediatricians may play a role in mental health care screening, evaluation, treatment, and/or follow-up.

Payment for Non-covered Services
If mental health benefits are not part of the health plan, or if the pediatrician is not part of the network, the family would be financially responsible for mental health services. The clinician should obtain a waiver or advance beneficiary notice prior to providing non-covered services. A waiver is a statement that a patient/parent/guardian signs acknowledging that the requested service is, or may not be, covered by health insurance and accepting responsibility for payment for the service. The waiver may be accompanied by a request for payment for the service at the time of the service. Clinicians should seek the advice of legal counsel before incorporating the use of waivers into their practice, as the use of waivers may not be permitted by the terms of contract(s) with the third-party payer or state law.

Managing Denials and Appeals
When facing denials by carriers, strategies include filing appeals and negotiating contractual provisions. A sample letter to send to carriers on bundling and carve-outs is included.

Filing Appeals
Pediatric practices can follow these general guidelines when appealing claim denials or partially paid claims (excerpted from Appealing Claim Denials Can Improve the Bottom Line, AAP News, June 2004):

1. Review all carrier explanation of benefits (EOB). Compare the billed amount and Current Procedural Terminology (CPT) codes with the EOB to determine the level of discounts, denials, inappropriate carrier re-coding, or partial payments.
2. Make sure that the claim was prepared properly, that all information is correct, and that documentation supports the CPT codes. Once assured that the denial was not due to an error on the practice’s part, proceed with the appeal.
3. Send appeal in writing and to the right person—look up the contact person in the contract or call the carrier, explain the situation and what is coming so they can be on the lookout. If you are not satisfied with the response, contact the plan’s medical director.
4. Send the appeal by certified mail to verify receipt by the health plan.
5. List the member’s name, carrier identification number, and claim number on all documentation.

6. State your case in objective and factual terms. Identify the result you want and provide medical justification and CPT coding guidelines to support your case (keep in mind most claim processors do not have a medical or coding background, so be clear and specific). Sample appeal letters that can be used as templates are available on the Member Center of the American Academy of Pediatrics (AAP) Web site (www.aap.org/moc) under the Private Payer Advocacy page.

7. Suggest how denials can be avoided in the future, particularly if it is a recurring problem.

8. Monitor for a response. If the carrier does not respond within the time frame specified in your initial appeal, follow up with a second letter.

9. Create a spreadsheet to track appeals to each carrier so that, at contract renewal time, you can determine whether to continue to work with that carrier and identify items to modify in the contract.

10. Each health plan should have a written statement explaining the procedures required for both first and second level appeals. If it is not excluded in the contract, and the practice has correctly coded and properly documented the services, continue to appeal. Should further action be required, contact the state department of insurance or depending on the state in which you practice, the state department of banking and insurance or state department of health. Most states have prompt pay laws. If a managed care organization violates the prompt pay law, the physician may be eligible for interest payments on the amount owed, depending on state law.

11. If a claim is denied and the health plan informs the practice that the service is not covered or is the plan member’s responsibility, bill the plan member and include a copy of the EOB and denial with the bill.

12. Contact your AAP chapter to keep it aware of your issues. Some chapters have pediatric councils that meet regularly with health plan medical directors and Medicaid representatives to address coverage issues. Utilize the AAP Hassle Factor Form to report problems with carriers. (Some chapters have made the Hassle Factor Form available on their Web site, or it can be accessed on the Member Center, under the “More Resources” link.)

**Negotiating Contractual Provisions**

In contacts with the health plans to discuss contractual issues, the key components are to:

1. Address the issue of benefit coverage with the person who has authority to make decisions regarding payment. The carrier provider representative may not have the decision-making authority in this type of matter.

2. Focus the argument on how this is cost-effective to the family and health plan, as well as how it relates to quality care. (Provide documentation supporting your position.)

3. Frame your position around the impact on quality of care, cost-effectiveness, and patient satisfaction. Carriers are very conscious of quality issues, how a proposed change will affect overall expenses and efficiency, and their market
share. The carrier’s current policy may not cover mental health-related services, and the carrier needs to be made aware of the impact to the patient, family, pediatrician, and carrier.

4. Consider notifying the family and employer, since they may bring pressure onto the carrier and employer to expand health plan coverage.

5. If a carrier refuses to cover medical providers for services related to mental health, the practice then needs to decide whether to provide the service or refer the family to the plan’s network mental health professional for those services and inform the family that it is the family’s insurance carrier requirement. The family and/or employer, as the purchaser, then may bring pressure onto the health plan to expand coverage.
mental health services: sample carrier letter

strategies for system change in children’s mental health: a chapter action kit

(place on chapter or practice letterhead)

TO:      Claims Processing Department or Health Plan Medical Director

RE:       Bundling services related to mental health evaluation and treatment
Claim # ______________________

I would like to clarify that Current Procedural Terminology (CPT) guidelines indicate that services identified with specific codes should be reported separately from any other code and, therefore, they should not be “bundled” into any other code(s). Unfortunately, many carriers are unaware that they are violating CPT guidelines in inappropriately bundling together 2 services when each has a separate CPT code. This concept is found throughout CPT guidelines. Some examples include

- “If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing a preventive medicine service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M (Evaluation and Management) service, then the appropriate Office/Outpatient code 99201-99215 also should be reported. Modifier–25 should be appended to the Office/Outpatient code to indicate that a significant, separately identifiable E/M service was provided by the same physician on the same day as the preventive medicine service” (CPT 2006 [professional edition], page 30).

- “If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough Immunizations and ancillary studies involving laboratory, radiology, other procedures, or screening tests identified with a specific CPT code are reported separately” (CPT 2006 [professional edition], page 30).

The CPT guidelines are applicable to any other screening tests or procedures that are identified with a specific CPT code, such as developmental testing and psychological or behavioral assessment. Therefore, physicians are correct in reporting such services separately from any accompanying E/M service. While there is no legal mandate requiring private carriers to adhere to CPT guidelines, it is considered a “good faith” gesture for them to do so, given that the guidelines are the current standard within organized medicine. Those separately reportable services that are not recognized by a carrier should be designated non-covered benefits and billable to the patient.

Enclosed is a copy of the original claim that was submitted with a request that you process payment as indicated on the claim. I look forward to receiving your response. If you have any questions, please feel free to contact me at ______________________.

Sincerely,
TO: Claims Processing Department or Health Plan Medical Director

RE: Developmental testing
Claim # ________________________

I am writing to you regarding the above claim and your practice of bundling the developmental testing (Current Procedural Terminology [CPT] 96110) with the preventive medicine code (99381-99397). I ask that you reconsider this in light of the following.

Current Procedural Terminology code 96110 (developmental testing; limited [eg, Developmental Screening Test II, Early Language Milestone Screen], with interpretation and report) should be reported separately from a preventive medicine service code (99381-99397) when a developmental test is interpreted and a report is developed from that interpretation during the course of a well child exam. It is important to note that the interpretation and report must constitute a significant, separately identifiable service from the preventive medicine visit. Examples of when it would be appropriate to report CPT code 96110 in addition to a preventive medicine service code include:

- Two-year-old well child care visit; physician administers Brigance screening tool (physician administers via face-to-face interview, 10 minutes)
- 30-month-old well child care visit, review of Parents’ Evaluation of Developmental Status (PEDS) questionnaire (parent completes for 10 minutes, physician reviews results with the parent for 3 minutes)
- Three-year-old well child visit, physician administers Child Development Inventory checklist (physician administers via face-to-face interview, 2 minutes)

If a less formal developmental assessment is conducted, it would be included in the preventive medicine service code or, alternatively, if a mini-mental status examination is conducted by the physician, it could be reported with an office or other outpatient services code (99201-99215).

Enclosed is a copy of the original claim that was submitted, with a request that you process payment as indicated on the claim. I look forward to your response to this matter. If you have any questions, please feel free to contact me at ____________________.

Sincerely,
Overview

Within the last 20 years, the role of mental health care has become recognized as a critical component of America’s health care system. A 2004 survey conducted by the Center for Health and Health Care in Schools http://www.healthinschools.org/sh/psychotropic.pdf found that 19% of all pediatric visits involved a psychosocial problem requiring attention or intervention. In fact, psychosocial problems rank first, surpassing asthma and heart disease, as the chronic conditions that most often account for pediatric visits.

Childhood mental health issues can produce a negative effect on quality of life through adulthood, and the importance of early identification and treatment of mental health concerns cannot be overstressed. The economic impact alone of untreated mental health concerns is staggering. Untreated mental health disorders lead to higher rates of juvenile incarcerations, school dropout, family dysfunction, drug abuse, and unemployment. Societal costs can be alleviated by early detection and treatment of mental health conditions.

This issue brief focuses on 4 distinct topics:

- The establishment of parity between insurance coverage for mental health care and physical health care.
- The prevention of suicide in children and adolescents.
- The use of school-based mental health programs in identifying and treating mental health conditions.
- The administration of psychotropic medications to children and referral for psychotropic medications by school personnel.

Mental Health Insurance Parity

The National Institute of Mental Health (NIMH) http://www.surgeongeneral.gov/topics/cmh/ reports that it is estimated that less than 1 in 5 of the children and adolescents, who suffer from mental illness severe enough to cause some level of impairment, receive treatment for their condition. According to the AAP Policy Statement “Insurance Coverage of Mental Health and Substance Abuse Services for Children and Adolescents: A Consensus Statement” http://aappolicy.aapublications.org/cgi/content/full/pediatrics;106/4/860 it is currently estimated that at least 13 million children are in need of mental health or substance abuse services, yet attempts to restrain health care costs have resulted in decreased availability of mental health and substance abuse services for children and adolescents.

The Mental Health Parity Act (MHPA) of 1996 prohibited employer-sponsored group plans larger than 50 employees, from imposing annual or lifetime maximums on mental health benefits that are lower than those imposed on other benefits. Despite the name, the law does not require parity between mental health benefits and other illness coverage benefits in the terms of deductibles, outpatient visit limits, inpatient day limits, and medical necessity requirements or prior authorization requirements. To fill in the gaps left open from the MHPA, every state except for Wyoming has enacted some form of mental health parity legislation. In February 2007, legislation was introduced in the U.S. House of Representatives that would require mental health substance and abuse treatment parity for employer-sponsored insurance plans with 50 or more employees. As of this writing, this legislation is still pending.
AAP Recommendations

Many children do not receive preventive or follow-up care for mental health conditions. The Academy makes the following recommendations in the consensus statement:

- Parity should be established between medical health services and mental behavioral and substance abuse services.
- The State Children’s Health Insurance Program (SCHIP), which has provided additional resources for children’s health care and has allowed for some flexibility in the distribution of resources, should be supported and expanded to include coverage for mental and behavioral health and substance abuse services.
- The number of qualified child mental health and substance abuse clinicians should be increased through support for training programs, better recruitment into these programs and job incentives.
- Managed care and behavioral health organizations should be required to provide adequate panels of culturally competent clinicians who are qualified to address child and adolescent mental and behavioral health and substance abuse needs.
- Competent, licensed providers with training and expertise in providing services to children should be equally included on panels, without limitations to specific disciplines.
- Professionals need to be accessible and available to families within a reasonable distance and time frame.
- Services provided by clinicians in alternative sites such as schools, homes, and centers must be reimbursed.
- Families and purchasers of health care plans need to be clearly informed about the adequacy of the health care coverage they are considering. The health plan should specifically identify mental health services provided to children, including child and adolescent psychopharmacology, child and adolescent psychological and neuropsychological assessments, child and adolescent psychotherapy, behavioral medicine (eg, pain management, chronic illness management, eating disorders), and substance abuse programs.

State Activity

Mental Health Parity Laws

Currently 5 states (Connecticut, Maryland, Minnesota, Oregon, and Vermont) mandate mental health parity, requiring that all mental health conditions and substance abuse disorders be covered at the same level as a physical illness.

Limited Mental Health Parity Laws

Three (3) states (Indiana, Kentucky, and Maine) require mental health and substance abuse treatment parity only in group insurance plans with 50 or more employees. Rhode Island requires that both mental health and substance abuse conditions be covered at the same rate as other physical illnesses, with some limitations on outpatient visits. Two (2) states (New Mexico and Washington) require mental health parity for group health plans with more than 50 employees, but do not include coverage for treatment of substance abuse in the mandate. Six (6) states (Arizona, Arkansas, North Carolina, Oklahoma, Tennessee, and West Virginia) require mental health parity within group health insurance coverage, provided that parity does not raise the cost of coverage by more than 1 to 2%. Idaho mandates mental health parity in coverage only for state employees and their families.

Eight (8) states (California, Colorado, Delaware, Louisiana, Montana, New Hampshire, New Jersey, and South Dakota) limit mental health parity to people determined to have “Severe Mental Illness” (SMI). The definition of SMI varies from state to state, but is generally accepted to mean a biological-based mental illness. Eight (8) other states (Hawaii, Illinois, Iowa, Massachusetts, Nebraska, South Carolina, Texas, and Virginia) limit mental parity to treatment of SMI in group insurance plans.

Mental Health Mandates

Twelve (12) states (Alabama, Alaska, Florida, Georgia, Kansas, Michigan, Mississippi, New York, North Dakota, Ohio, Pennsylvania, and Wisconsin) mandate mental health care coverage within private health insurance, but do not stipulate in these mandates that mental health care coverage and physical illness coverage be equal. Two (2) states (Nevada and Utah) have laws that limit out-of-pocket expenses for treatment of SMI within group health insurance plans and Missouri limits out-of-pocket expenses on coverage of all mental health conditions.

Recent Legislative Activity

During the 2007 legislative session, 10 states introduced bills that would require or strengthen mental health parity with medical benefits. Colorado passed legislation that will require insurers to cover coverage for mental disorders in addition to SMI. New Mexico passed a bill that will allow residents with an individual insurance policy, which does not include mental health benefits, the eligibility to buy into a pool policy to provide mental health services. Washington passed a bill that will require existing mental health benefits to be extended to small employer and individual plans. West Virginia removed the sunset clause for mental health parity laws for group plans.
School-Based Mental Health Programs
Access to mental health coverage is not the only barrier to children’s mental health care. The AAP Policy Statement “School-Based Mental Health Services” http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;113/6/1839 reports that barriers also include lack of transportation, financial constraints, child mental health professional shortages, and stigmas related to mental health problems. These barriers might explain why 40% to 60% of families who begin therapy sessions end prematurely, and why most people only attend 1 to 2 sessions before terminating. School-based mental health services are evolving as a strategy to address these concerns by removing barriers to accessing mental health services and improving coordination of these services.

AAP Recommendations
The Academy recognizes that school-based mental health clinics can play an important role in addressing barriers to mental health services and makes the following recommendations:

- The mental health program (preventive strategies and mental health services) should be coordinated with educational programs and other school-based health services. School social workers, guidance counselors, school psychologists, school nurses, and all mental health therapists should plan preventive and intervention strategies together with school administrators and teachers, as well as families and community members.
- Preventive mental health programs should be developed that include a healthy social environment, clear rules, and expectations that are well publicized. Staff members should be trained to recognize stresses that may lead to mental health problems as well as early signs of mental illness and refer students to trained professionals within this setting.
- Mental health referrals (within the school system as well as to community-based professionals and agencies) should be coordinated by using written protocols, should be monitored for adherence and should be evaluated for effectiveness.
- School-based specific diagnosis screenings, such as for depression, should be implemented at school only if they have been supported by peer-reviewed evidence of their effectiveness in the setting.
- Roles of all the various mental health professionals who work on campus with students should be defined so that students, families, all school staff members, and the mental health professionals themselves understand them.
- Group, individual, and family therapies should be included as schools arrange for direct services to be provided at school sites. Alternatively, referral services should be available for each of these modes of therapy so that students and families receive the mode most appropriate to their needs.
- It should be documented that mental health professionals providing services on site in school (whether hired, contracted, or invited to school sites to provide services) have training specifically in child and adolescent mental health (appropriate for student ages) and are competent to provide mental health services in school settings.
- Private, confidential, and comfortable physical space should be provided at the school site. Often, this is not difficult for schools if mental health services are provided after school hours. Having school-based services should not preclude the opportunity for mental health services to be provided at nonschool sites for situations in which therapy for a student may be ill advised (eg, student who feels uncomfortable discussing a history of sexual abuse in a school setting). During extended school breaks, schools must provide continued access to mental health services.
- Staff members should be provided with opportunities to consult with child psychiatrists or clinical psychologists (on or off school site) so that they may explore specific difficult situations or student behaviors and review policies, programs, and protocols related to mental health.
- Quality-assurance strategies should be developed for mental health services provided at school, and all aspects of the school health programs should be evaluated, including satisfaction of parent, student, and third-party payers and mental health professionals.
- Confidentiality of health information should be maintained as required by law.

State Activity
School-based mental health centers are typically developed and run by individual school districts utilizing funding from federal, state, and local resources. According to a study by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), while school districts operating school-based mental health clinics are found in nearly every state, only 17% of school districts currently operate them. However, the number of school districts with mental health clinics is continuing to grow, fueled...
in part by state initiatives. States are exploring options for achieving permanence and expanding to other school districts by passing legislation that authorize school-based mental health clinics, facilitating agency collaboration through an interagency memorandum of understanding, or through an executive order from the governor establishing mental health authority within the state education departments. States are also exploring establishing additional state funding, requesting additional federal funds, or establishing legislative task forces to determine the best methods to fund a statewide program.

In 2007, Connecticut introduced a bill that would provide 2 million dollars to create and fund school-based mental health clinics in the state. In 2006, California and Colorado allocated state funding specifically for school-based mental health centers for the first time. Illinois passed a bill that allowed school health centers to be considered as primary care providers to allow for Medicaid and private insurance payment of providers.

Federal Activity
In February of 2007, the U.S. Senate introduced a bill that would provide direct federal funding in the form of grants to school-based health centers. Currently, many school districts in local communities throughout the United States are utilizing federal funding from already established sources to pay for mental health services in school settings. Using braided or blended federal funds such as Medicaid (Early and Periodic Screening, Detection and Treatment (EPSDT), State Children’s Health Insurance Program (SCHIP), or Individuals with Disabilities Education Act (IDEA) to finance these services within schools, allows school districts to incorporate existing school funds with potentially untapped resources to create or expand mental health programs within their schools. See more about the potential use of braided or blended federal funds to subsidize children’s mental health services in “How Children’s Mental Health Services are Financed” in the AAP Mental Health Chapter Action Kit.

Suicide Prevention
Suicide is the third leading cause of death of children between the ages of 15-19. In recent years suicide rates have been declining, but according to statistics from the Centers for Disease Control and Prevention (CDC) published in the February 2007 issue of Pediatrics, adolescent suicide rates increased by 18% from 2003 to 2004, making it the only cause of death for children that increased in this period.

These alarming rates are even higher among one segment of the adolescent population. The AAP Clinical Report, “Sexual Orientation and Adolescents” notes that school-based studies have found that adolescents who self-identify as gay, lesbian, or bisexual are 2 to 7 times more likely to attempt suicide compared with heterosexual peers. The report also notes that these psychosocial problems and suicide attempts in nonheterosexual youth are neither universal nor attributable to homosexuality per se, but they are significantly associated with stigmatization of gender nonconformity, stress, violence, lack of support, dropping out of school, family problems, acquaintances’ suicide attempts, homelessness, and substance abuse.

AAP Recommendations
The AAP Policy Statement “Suicide and Suicide Attempts in Adolescents” urges that the following provisions be included in state suicide prevention plans:

- Promoting school-based initiatives.
- Gatekeeper training for those who are able to observe high-risk behavior among youth.
- School-based suicide prevention programs that incorporate screening and suicide prevention information into health and human services.
- Crisis intervention services for schools and communities that provide a rapid response to tragic events.
- Establishing statewide crisis hotline and information for consultation and education services.
- Increasing access to and the coordination of mental health and substance abuse services.
- Reducing child and adolescent access to lethal means of self-harm, such as firearms.
- Forming public and private partnerships to raise community awareness.

Because of the higher rate of suicide attempts among gay, lesbian, and bisexual youth, the AAP Clinical Report, “Sexual Orientation and Adolescents” notes, “It is critical that schools find a way to create safe and supportive environments for students who are or wonder about being nonheterosexual or who have a parent or other family member who is nonheterosexual.” In addition, the report encourages community advocacy by pediatricians to:

- Help raise awareness among school and community leaders of issues relevant to nonheterosexual youth.
- Help with the discussion of when and how factual materials about sexual orientation should be included...
in school curricula and in school and community libraries.

- Support the development and maintenance of school- and community-based support groups for nonheterosexual students and their friends and parents.
- Support HIV and AIDS prevention and education efforts.
- Develop and/or request continuing education opportunities for health care professionals related to issues of sexual orientation, nonheterosexual youth, and their families.

### State Activity

Forty-three (43) states (including the District of Columbia) have suicide prevention plans, and 7 states have plans in development. North Carolina is the only state without a suicide prevention plan or without one in development. In addition to suicide prevention plans, Tennessee has introduced legislation requiring teachers to undergo suicide prevention training.

### Federal Activity

The federal Garrett Lee Smith Memorial Act enacted in 2004, authorized $82 million in federal spending for suicide prevention in fiscal years 2005, 2006, and 2007. Through the Substance Abuse and Mental Health Services Administration (SAMHSA), the law appropriates funding to assist states and educational institutions in establishing early intervention and detection programs for suicide prevention.

### Psychotropic Medications

An estimated 4 million U.S. children have been identified as having attention deficit/hyperactivity disorder (ADHD), while 1% of children and 5% of adolescents have been diagnosed with depression. Within the past 20 years, advances in medication have allowed these conditions formerly treated with behavior modification therapy to be treated with drugs designed to regulate the brain’s chemistry. Recent studies showing the increased threat of suicidal thoughts from the administration of antidepressants to children and adolescents, have cautioned physicians in the use of specific psychotropic medications in treatment of mental health disorders. A backlash from the perceived “over-prescription” of psychotropic medications for children with ADHD among some groups added to a public policy debate about the merits of psychotropic medication to treat ADHD and other mental health disorders in children. These controversies have the potential to stigmatize the use of psychotropic drugs, which have been proven to be safe and effective in the treatment of mental health disorders, and may cause parents to become hesitant to administer these medications to their children.

### AAP Recommendations

While the Academy supports the use of caution when prescribing antidepressant medications to children and adolescents, the Academy’s main concern is to ensure access to the best therapies for children who suffer from mental disorders. The Academy has expressed concerns through communications with the Federal Drug Administration (FDA) that “black box” warnings may discourage pediatricians from prescribing needed medications to children and adolescents. The decision to prescribe medication to address depression or other mental health conditions in a child should be left up to the child’s physician in consultation with the parents and the child.

Academy policy concerning treatment of ADHD outlined in “Clinical Practice Guideline: Treatment of the School-Aged Child With Attention-Deficit/Hyperactivity Disorder,” (http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/4/1033) recommends that the treating clinicians work in conjunction with parents and teachers to target appropriate outcomes to guide the management of ADHD. It is important that school personnel not be subjected to a real or perceived “gag order” when discussing the presence and appropriate response to ADHD. While teachers should not be diagnosing ADHD in children, the teacher and other school personnel should work in conjunction with a child, their parents, and the child’s medical home when a biological cause is suspected of hindering the child’s academic performance or creating behavioral disturbances. Teachers and parents should both actively monitor target outcomes and adverse effects.

### State Activity

State legislatures are using mandates directed at schools, state child custody systems, and child welfare services as a mechanism to limit access to psychotropic drugs. Two (2) states (Connecticut and Utah) have enacted laws that stipulate that failure or refusal to administer psychotropic medications to children does not warrant neglect or abuse. Seven (7) states (Colorado, Delaware, Florida, Illinois, Minnesota, Texas, and Virginia) have passed laws limiting nonmedical school personnel from recommending that a student be prescribed medications or place sanctions on a child whose parents refuse to administer psychotropic medications. Meanwhile, 2 states (California and Illinois) allow school personnel with medical training to recommend that a student be examined for ADHD and/or prescribed psychotropic medications to treat the disorder. Nine (9) state legislatures (California, Connecticut,
Florida, Hawaii, Louisiana, North Carolina, New Mexico, Texas, and Washington) have authorized studies monitoring the use of psychotropic medications to children in state custody. Five (5) states (Delaware, Georgia, New Hampshire, North Carolina, and Virginia) have established legislative committees/tasks forces to study the number of children within their states diagnosed with ADHD and/or administered medication. Two (2) state boards of education (Colorado and Texas) passed resolutions promoting the use of academic management to address behavioral problems rather than a psychiatric approach. Finally, Indiana requires all medical practitioners prescribing psychotropic medications to children to follow the AAP Clinical Practice Guideline: Diagnosis and Evaluation of the Child With Attention-Deficit/Hyperactivity while evaluating children for ADHD.

In 2007, Utah enacted legislation that would prohibit school personnel from recommending that a child be prescribed psychotropic drugs or prohibiting a child from a classroom based on a parent’s refusal to administer psychotropic drugs. California enacted legislation that allows only a judicial court officer to make orders regarding the administration of psychotropic drugs. Hawaii passed legislation that prohibits the Department of Human Services from restricting coverage or access to psychotropic drugs.

Federal Activity

In 2004, the Federal Drug Administration (FDA) required all antidepressant medications to include a “black box” warning prominently displayed on the label providing information regarding potential medical complications associated with the drugs, including increase in suicidal thoughts and behaviors.

In early 2005, the FDA’s Drug Safety and Risk Management Advisory Committee met and recommended that the FDA label certain stimulant prescription drugs for ADHD with a black box warning. However, a separate pediatric advisory committee rejected the call for a black box warning on ADHD medications and instead recommended adding more information to the labels for the benefit to the doctors, parents, and patients, providing parents with a medication guide that would tell parents to discuss with their doctors if their child experienced hallucinations, and alerting parents that ADHD medications can increase the risk for a heart attack and a stroke among people with undiagnosed heart problems.

Advocacy Considerations

- **Emphasize the Impact of Early Detection on a Child’s Life.** Mental health disorders can have a negative impact of the quality of a child’s life for years to come. If addressed early in childhood, the child will be less likely to exhibit poor school performance, less likely to commit crimes later in life, and will exhibit increased self-esteem and confidence that will allow them to become healthy, productive adults.

  
  [http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860)

- **Seek Pediatrician Appointment to State Mental Health Advisory Committee.** When considering mental health policy, state policy makers may overlook the role of the primary care provider. Pediatricians are often the first stop in diagnosing and developing a plan to treat mental health conditions, and therefore should become actively involved in formation of state health mental policy by working with their chapters to seek appointments to state advisory boards and committees.

- **Use Patient Stories to Illustrate Need for Change.** Individual stories, when utilized with appropriate confidentiality measures, can be the best tool for advocating changes to the current system. Policy makers are often swayed more by an individual case than statistics that point to the same conclusions. Identify a family with a poignant story who would agree to share their story with state officials through testimony. If the family would prefer not to testify, have them share their story through letters to or meetings with their legislator. Letters from children and adolescents affected by a mental health condition accompanied by a parent’s letter are often the most effective advocacy tools.

- **Highlight Improved State Budgets as Opportunity to Improve Access to Health Care for Children.** Legislators are no longer facing the barren coffers within their state budgets that plagued them the early part of the decade. For the first time since 2000, almost all states are expecting a budget surplus. This presents an excellent opportunity to expand current and fund new children and adolescent mental health programs.
Resources
AAP Consensus Statement: Insurance Coverage of Mental Health and Substance Abuse Services for Children and Adolescents: A Consensus Statement
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/4/860

AAP Policy Statement: Suicide and Suicide Attempts in Adolescents
http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;105/4/871

AAP Policy Statement: Sexual Orientation in Adolescents
http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;113/6/1827

AAP Policy Statement: School-Based Mental Health Services
http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;113/6/1839

AAP Mental Health Task Force Chapter Action Kit: “How Children’s Mental Health Services are Financed”

Bazelon Center for Mental Health “Way to Go: School Success for Children with Mental Health Care Needs”
http://www.bazelon.org/newsroom/2006/6-7-6-WayToGo.html

National Conference of State Legislatures, “Table: Full Parity, Mandated Benefit and Mandated Offering State Laws”
http://www.ncsl.org/programs/health/Mentalben.htm

National Mental Health Association “What Have States Done to Ensure Parity”
http://www.nmha.org/state/parity/state_parity.cfm

NAMI Policy Institute Task Force Report, “Children and Psychotropic Medications”
http://www.nami.org/Content/ContentGroups/CAAC/NAMIs_Report_on_Children_and_Psychotropic_Medications.htm

The Robert Wood Johnson Foundation (RWJF) “Making the Grade: State and Local Partnerships to Establish School-Based Health Centers”
http://www.rwjf.org/reports/npreports/MakingGrade.htm

For more information on federal activities and advocacy, please contact: AAP Department of Federal Affairs at kids1st@aap.org or 202/347-8600. http://aap.grassroots.com/
During the past decade, a growing awareness of the social and economic costs of mental illness has prompted state legislators to mandate increases in the coverage of mental illnesses by private health insurance companies. These laws, commonly known as parity mandates, parity laws or simply “parity,” require equal coverage for the treatment of both mental and physical illness. This paper evaluates how institutional barriers—such as exemptions for small businesses, managed care organizations that act as gatekeepers for benefits, and federal restrictions on states’ powers to impose insurance mandates—may reduce the effectiveness of parity as a tool for ensuring coverage of mental health services for vulnerable populations. Parity is described by mental health advocacy groups—such as the National Alliance for the Mentally Ill (NAMI) and the National Mental Health Association (NMHA)—as a tool for improving coverage and reducing the stigma associated with mental illnesses. However, a number of factors may greatly reduce the effectiveness of parity mandates. These include managed care organizations that can act as gatekeepers to services; federal legislation that prohibits states from placing insurance mandates on self-funded health plans; and exemptions in both state and federal parity legislation for small employers that further limit the pool of people to whom parity is a relevant issue. Unfortunately, insufficient data and restrictive definitions of mental illness in parity legislation continue to limit the ability of researchers to determine the extent to which parity increases coverage of mental health services for vulnerable populations.

**Parity Defined**

Parity encompasses a variety of legislative approaches to ensuring adequate insurance coverage for mental health illnesses. Its definition often depends upon who is using the word. NCSL defines a law as *parity* if it “… requires an insurer to provide benefits for mental illnesses and/or substance abuse that are equal to those provided for other physical disorders and diseases.” The language of Vt. Stat. 8 V.S.A. §4089b (1997), the Vermont parity legislation implemented in 1997 that is widely hailed as the most comprehensive in the nation, states:

(b) *A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.*

Other types of legislation that are sometimes referred to as parity include *minimum mandated benefit laws* and *mandated offering laws*. Minimum mandated benefit laws typically specify base levels for mental health insurance coverage; benefits given under these provisions are not necessarily equal to those set for physical illnesses. A typical minimum mandated benefit law states, “… will require that benefits for “X” (“X” being mental illness and/or substance abuse), be provided at level “Y” (“Y” then specifies the degree top which “X” is covered). The following language from Pa. Stat. tit. 40 §764g (2004), Pennsylvania’s minimum mandated benefit law, provides an example of minimum mandated benefit law:

(c) *Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards: 1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually; 2) a person covered...*
under such policies shall be able to convert coverage of
inpatient days to outpatient days on a one-for-two basis; 3) there shall be no difference in either the annual or lifetime
dollar limits in coverage for serious mental illnesses and any
other illnesses; 4) cost-sharing arrangements, including, but
not limited to, deductibles and copayments for coverage of
serious mental illnesses shall not prohibit access to care. The
department shall set up a method to determine whether any
cost-sharing arrangements violate this subsection.5

Mandated offering laws require insurers to either offer the
option of mental health coverage to the insured, often with
a higher premium, or mandate that, if an insurer decides to
offer mental health benefits, they must be provided at a level
specified by the law.6 Utah Code §31A-22-625 (2002), a
Utah law, is an example of the first type of mandated offering
legislation, specifying that:

At the time of purchase and renewal, an insurer shall offer to
each small employer that it insures or seeks to insure a choice
between catastrophic mental health coverage and 50/50
mental health coverage.7

Fla. Stat §627.6685 (2004), a Florida insurance mandate, is an
example of the second type of mandated offering legislation,
amending:

(a)1. In the case of a group health plan, or health insurance
coverage offered in connection with such a plan, which
provides both medical and surgical benefits and mental
health benefits: a. If the plan or coverage does not include
an aggregate lifetime limit on substantially all medical and
surgical benefits, the plan or coverage may not impose any
aggregate lifetime limit on mental health benefits. b. If
the plan or coverage includes an aggregate lifetime limit on
substantially all medical and surgical benefits, the plan or
coverage must: (I) Apply that applicable lifetime limit both to
the medical and surgical benefits to which it otherwise would
apply and to mental health benefits and not distinguish in the
application of such limit between such medical and surgical
benefits and mental health benefits; or (II) Not include any
aggregate lifetime limit on mental health benefits which is less
than that applicable lifetime limit.8

In this paper, the term insurance mandate describes any
legislation that increases benefit levels or access to insurance
benefits. As figure 1 shows, many states have passed laws that
closely adhere to one of these definitions, while others have
blended aspects of two or more of the insurance mandate
types by passing more than one law pertaining to mental
health insurance coverage.

<table>
<thead>
<tr>
<th>FIGURE 1. MENTAL HEALTH INSURANCE MANDATES BY STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mandated Benefit</strong> AR, MD, MI, MS9, ND, NV, OR, PA, RI, TN, TX, VA</td>
</tr>
<tr>
<td><strong>Mandated Offering</strong> AL, AZ, FL, GA, IN, KS, KY, IA, MO, NE, NY, OH, UT, WI</td>
</tr>
<tr>
<td><strong>Parity</strong> CA, CO, CT, DE, HI, IL, MA1, ME, MN9, MT1, NC9, NH9, NJ1, NM, OK, SC9, SD9, VT, WA, WV</td>
</tr>
<tr>
<td><strong>No Requirement</strong> AK, IA, ID, WY</td>
</tr>
</tbody>
</table>

**Notes**
1. Massachusetts and New Hampshire mandate parity coverage for biologically based mental illness; there is a mandated
benefit for all DSM diagnosis not covered under the parity provision.
2. Minnesota has a parity mandate for HMOs and a minimum mandated offering for group and individual plans.
3. Mississippi has a mandated offering for small providers with 100 employees or less, and a mandated benefit for all
other businesses.
4. Montana mandates parity for severe mental illness and has a mandated benefit clause for other forms of mental illness.
5. New Jersey mandates parity for biologically based illnesses and has an alternative mandated offering for individual
coverage.
6. North Carolina and South Carolina mandate minimum benefits for state employees.
7. South Dakota mandates parity for biologically based mental illness.

**Source:** McKinley, Behavioral Health: Parity and Other Insurance Mandates for the Treatment of Mental Illness and Substance Abuse (Washington, D.C.: NCSL Health Policy Tracking Service, 2004).
Talking Ethics: Parity and Values

Insurers and advocacy groups strongly disagree about the merits of parity. At the heart of the debate is a dispute over what government should mandate. Opponents believe that insurance mandates limit freedom of choice by imposing increased costs on businesses and individuals for services they may not want or be able to afford. Proponents hold that parity in insurance coverage of mental illness helps fulfill an obligation to ensure social equity by increasing access to, and use of, health services.

Mental health advocates explain that parity reduces the stigma and discrimination associated with mental illness that led to inequitable differences in coverage. NAMI, a prominent advocacy group representing consumers and families, states that “…there is simply no scientific or medical justification for insurance coverage of mental illness treatment to be on different terms and conditions than other diseases.” The organization holds that mental health is a fundamental right and services that maintain it should be available to everyone. Proponents also state that mental health is a crucial component of overall well-being because mental ailments often are associated with higher levels of physical illness. Such groups cite data that shows that mental illness leads to higher expenditures by public and private health insurance providers through lost productivity due to absenteeism (missed workdays) and elevated expenditures on visits to the doctor for treatment of physical illnesses related to mental ailments.

Opponents of parity, including employer and insurer groups, focus on the importance of freedom and choice, describing insurance mandates as additional costs for businesses and consumers. The nation’s largest business lobbying group, the U.S. Chamber of Commerce, states that insurance mandates, “…artificially raise the cost of health plans, limit employers’ ability to tailor benefits according to workforce need and demand, and stifle health plans’ efforts to provide consumers with a variety of choices.” That is, the additional costs associated with mandates are passed along to consumers in the form of a decrease in insurance products on the market. As a result, they say, consumer choice declines. Opponents also assert that increased costs for employers and workers lead to decreased coverage: “When workers have to bear more of the cost of their group health coverage, they opt out of insurance programs – jeopardizing their overall health status.”

Although both sides in this debate make cost-efficiency arguments to support their positions, the debate often is framed in terms of values. At the heart of the issue is a disagreement about the relative importance of equity versus freedom of choice in health services.

Managed Care and Parity

Economic theory suggests that, in the absence of direct personal costs, people tend to overuse health services, which drives up system costs. Parity increases access to services, which indicates that usage also will increase. Many insurers use managed care systems that attempt to rein in health spending by controlling access to and use of health services. There is, however, some concern about the effectiveness of parity in a managed care environment: parity increases offerings, while managed care limits usage. Parity legislation of all types seeks to increase coverage of mental health services in private insurance plans. In contrast, managed care systems such as health maintenance organizations (HMOs) or managed care organizations (MCOs) use a variety of techniques to monitor and direct the use of health care services by members to contain costs, improve the quality of services, or both. Given the influence of managed care organizations in the field of mental health care, advocates have been concerned about the effect of managed care on access to mental health benefits.

Optimally, managed care services can improve the quality and appropriateness of the services that people receive: managed care plans that focus on preventive care can actually increase access to primary care, reducing the likelihood that a person will need more costly urgent care later in life. A trend in managed care that may alleviate some advocates’ concerns is the use of carve-outs, which are health care payer systems wherein insurers form agreements with specialized contractors to administer and fund mental health services separately from physical health services. Commonly stated reasons for using carve-outs include controlling system costs and improving service quality for targeted populations. Some reviews of carve-out systems suggest that, at least in the private market, “…costs have been contained, while access to any behavioral specialty care has tended to remain constant or even increase.” This suggests that carefully designed systems that couple parity and managed care may be able to control costs while targeting additional benefits to those in need. The issue of system design remains a major concern because constructing a network of providers to supply services in a carve-out can be difficult. This may lead to limits on access to services despite official insurance coverage.

Parity Implementation

Studies examining the effects of parity on cost and access to services in managed care have found that spending generally does not increase. Notably, the U.S. Department of Health and Human Services conducted an evaluation of Vermont’s 1997 parity law, which is among the most comprehensive parity law in the nation. The resulting report, which gathered data from the first two to three years after parity was implemented in Vermont, concludes that “…increased use of managed care helped make parity affordable but may have reduced access and utilization for some services and beneficiaries.” The authors of the Vermont report explained that access to outpatient mental health services improved,
Paying for health care services for mentally ill children is a significant hardship for many families around the country. The 1999 Mental Health: Report from the Surgeon General suggests that 4 million American children between the ages of 9 and 17 suffer from a “significant functional impairment” from mental illness and “have a high need for services.” As figure 2 shows, approximately 1 child in 10 will need some form of therapy, and roughly 1 in 20 will face extreme need.

Many of these children do not receive adequate mental health services. A recent Kaiser Family Foundation report states that, “... although nearly all covered workers (98%) have mental health benefits, limits on the number of visits for outpatient care and the number of days for inpatient care remain a common feature for all plan types.” These restrictions generally apply to dependents who receive benefits through their working parent or spouse. Consequently, the parents of children with mental illness often pay for the cost of treatment out-of-pocket.

When high-cost or long-term care is necessary, those payments can exceed parents’ financial resources, forcing them to make difficult decisions, such as spending down their resources until they qualify for Medicaid services. This occurs when parents are too well-off to qualify for Medicaid but too poor to pay for all the necessary services on their own. As an alternative, many families relinquish custody publicly funded mental health services. A recent report by the General Accountability Office (GAO) estimates that, in the United States, more than 12,700 children were voluntarily relinquished to state custody in 2001 solely to give them access to mental health services.

Children become wards of the state when relinquished, cycling through the foster care system despite the fact that their parents may want to take care of them. Solutions to this problem have been slow in coming. Although it is increasingly clear that community-based services can help keep families together and reduce trauma, it is also apparent that supplying additional services costs money, of which states have limited supply.

Mental health advocates suggest that mental health parity may increase coverage of health care services for children, thereby reducing the rate of custody relinquishment. However, the strength of the effect of parity on custody relinquishment has not been sufficiently examined. The degree to which increases in coverage can affect the rate of custody relinquishment and increase access to health care for mentally ill children is a function of how effectively insurance mandates can target specific populations. Several factors seem to create barriers to the targeted use of parity as a solution to custody relinquishment, among them the advent of managed care systems to control health care use, as well as exclusions from parity that may be granted to small and self-insured businesses by states and the federal government. Little research has been conducted to examine how these dynamics affect parity and child custody relinquishment.

This information gap highlights the value of research to policymaking: using parity legislation as a solution to the problem of custody relinquishment of children assumes an ability to target resources to members of this vulnerable population. It is not clear that parity can help provide a solution. Future steps that could help clarify this issue might include identifying the families of children with mental illness at the state level. Additional research could examine how the degrees and types of need vary by family income level, location, and so forth. Determining who needs assistance, how much, and in what mix could help reduce the number of children who are relinquished by their parents in order to receive services. As a result, state foster systems would bear less of the burden of providing for children with severe mental illnesses.
Many states have used the primary federal parity legislation, the Mental Health Parity Act (MHPA), which was passed by Congress in 1996 with a yearly sunset, as a template for their insurance mandate laws, adding additional exemptions and inclusions in each new iteration. As a result, parity is a patchwork of federal and state legislation, with all the complications that such a structure implies.

The Centers for Medicare and Medicaid Services suggests that the federal parity act “… may prevent your group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower—less favorable—than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.” However, as they also take care to point out, “… MHPA does NOT require group health plans and their health insurance issuers to include mental health coverage in their benefits package.” In this respect, the MHPA conforms to the National Conference of State Legislature’s definition of a mandated offering because it compels insurers to offer equal coverage for mental illnesses in their insurance benefit packages if they offer mental health insurance coverage. Insurers can, however, choose to not offer mental health insurance coverage or to offer an optional mental health benefit package with a higher premium. Other specific provisions of the law include an exemption for small businesses with fewer than 50 employees, and an exemption for group insurers that can demonstrate a percent or greater cost increase in the cost of insurance due to the law. Group insurers can be thought of as the bulk purchasers of health insurance policies; they are employers’ groups and associations such as unions that cannot efficiently self-insure but that can pool their purchasing power to buy discounted coverage from insurance companies. As table 1 shows, many states include similar exemptions in their legislation, thus shielding small business and insurers from the risk of cost increases but also restricting the pool of people affected by state parity legislation.

A significant difference between federal and state insurance mandates is that the MHPA applies to the self-funded insurance plans that many large businesses maintain for their employees. Whereas the Employee Retirement Income Security Act (ERISA) generally precludes states from passing laws regulating the self-funded health insurance plans that many large employers provide for their workers, the Mental Health Parity Act does apply to those plans. Of the estimated 63 percent of firms that currently offer health insurance to their employees, approximately 54 percent have self-funded health insurance plans, “… in which the

<table>
<thead>
<tr>
<th>State</th>
<th>Small Business Exemption</th>
<th>Cost Increase Exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Alaska</td>
<td>5 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Arizona</td>
<td>50 employees or less</td>
<td>1% or more</td>
</tr>
<tr>
<td>Arkansas</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Colorado</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Hawaii</td>
<td>25 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Illinois</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Indiana</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Kentucky</td>
<td>51 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Louisiana</td>
<td>50 employees or less</td>
<td>1% or more</td>
</tr>
<tr>
<td>Maine</td>
<td>20 employees or less</td>
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</tr>
<tr>
<td>Michigan</td>
<td>None</td>
<td>3% or more</td>
</tr>
<tr>
<td>Mississippi</td>
<td>None</td>
<td>1% or more</td>
</tr>
<tr>
<td>Nebraska</td>
<td>15 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Nevada</td>
<td>25 employees or less</td>
<td>2% or more</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>50 employees or less</td>
<td>2% or more</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Tennessee</td>
<td>50 employees or less</td>
<td>1% or more</td>
</tr>
<tr>
<td>Texas</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Virginia</td>
<td>25 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>Washington</td>
<td>50 employees or less</td>
<td>None</td>
</tr>
<tr>
<td>West Virginia</td>
<td>None</td>
<td>State employees: 2%; 25 employees or less: 1%; 25 employees or more/HMOs: 2%</td>
</tr>
</tbody>
</table>

employer assumes direct financial responsibility for the costs of enrollees’ medical claims.” In other words, more than half of all private companies are not required to comply with state insurance mandates. It is also important for state policymakers to consider the rate of self-funded plans by firm size. As figure 3 shows, larger firms are more likely to self-insure than are smaller firms. Together, the federal ERISA law and exemptions provided to employers by both state and federal governments such as exemptions for businesses with less than 50 employees limit the ability of parity legislation to ensure coverage of mental illnesses.

**CONCLUSION**

The degree to which parity laws that are designed to increase insurance coverage of mental illness are actually helping people is unclear for three reasons: 1) managed care organizations can act as gatekeepers, controlling access to benefits; 2) federal legislation prohibits states from placing insurance mandates on self-funded health plans, greatly reducing the number of people affected by any state insurance mandate; and 3) exemptions for small employers in state parity legislation further limit the pool of employees affected by this type of legislation. Nevertheless, anecdotal evidence suggests that parity is helping some people by increasing coverage of selected mental illnesses under managed care arrangements such as carve-outs or those that place a strong focus on preventive care. Insurance costs have increased little when parity is implemented, perhaps because managed care organizations act as gatekeepers for mental health services.

For lawmakers who seek to understand this set of issues, better information about target populations would facilitate more effective policy. State-level reviews of how current private, state and federal institutional structures interact to determine who has benefits, and at what levels, could further clarify best practices for the design of future policy. Legislation drafted using this additional information could improve the ability of parity mandates to address the unmet needs of people with mental illness.

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**Figure 3. Percentage of Self-Funding Employers Exempt from State Parity Mandates by Firm Size**

Note: The Employee Retirement Income Security Act (ERISA) exempts from state insurance mandates most companies that have self-funded health insurance plans.


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Children and Mental Health Parity

NOTES

2. Ibid., 1-2.
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36. Ibid., 123.
37. Andrew McKinley, Behavioral Health: Parity and Other Insurance Mandates for the Treatment of Mental Illness and Substance Abuse.
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