

THE PATIENT PROTECTION
AND AFFORDABLE CARE ACT:
WILL PARITY FOR MENTAL HEALTH CARE
TRULY BE ACHIEVED IN THE 21ST CENTURY?

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Abstract

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA), which established significant changes to health care provisions in the

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United States. The goal of the PPACA was to return a realistic choice, as well as the right, of health care to all Americans. The PPACA was developed to provide health care that is affordable and accessible for all individuals across the lifespan. A novel change, in comparison to previous health care reforms, was the addition of mental health and substance abuse care as a right for all stakeholders. This population has consistently been ignored in previous attempts at health care parity, therefore, the PPACA has reached a new frontier in the treatment of a population that consists of approximately 18% of the US population. This paper will analyze the history of mental health care in this country, specifically the lack thereof, as well as why mental health has been ripe for the inclusion into the services to be provided. Lastly, an analysis of the disadvantages of the PPACA in mental health and substance use will be presented, with a particular focus on providers and the implications in the state of Florida.

Introduction

Mental health care has been, and consistently continues to be, a struggle in the United States.¹ The reason for this struggle is multidimensional, yet can be situated in a few main areas. Firstly, the field of mental health is still in its infancy, thus leading to a “cookbook” approach to care,² as opposed to “standards of care.”³ Secondly, funding for mental health care is often severely limited.⁴

¹ Kristen Beronio, Sherry Glied & Richard Frank, *How the Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care*, 41(4) J. BEHAVIORAL HEALTH SERVICES & RES. 410 (2014).

² The cookbook approach to care approach removes clinical reasoning and decision-making and does not fully address the individual patient in regards to their specific physical, emotional, psychological and cultural values.

³ Carl Salzman, *The Limited Role of Expert Guidelines in Teaching Psychopharmacology*, 29(2) ACAD. PSYCHIATRY 176 (2005).

⁴ Jürgen Unützer, Michael Schoenbaum, Benjamin G. Druss & Wayne J. Katon, *Transforming Mental Health Care at the Interface With General Medicine: Report for the Presidents Commission*, 57 PSYCHIATRIC SERVS. 37, 38 (2006) (“mental health benefits are typically more restricted and heavily managed

Lastly, patients often discuss limitations to acquiring and maintaining adequate mental health care under their insurance.⁵ True mental health care has only garnered its footing in the last fifty years, leaving far too much time for trial and error, and less focus on empirically validated treatments and primary prevention models.

I. Mental Health Care History in the United States

The history of mental health care in the United States is considerably limited in comparison to the advancements that have been made in medical care and research. Prior to 1956, all mental health care strictly occurred in one of two locations: in a locked institution or in the patient's home.⁶ These two locations left considerable room for mental health care growth, particularly at the outpatient, community level. Therefore, in 1956, the United States began the process of "deinstitutionalizing" mental health care services by creating community health centers and initiating the process of filling the dearth of mental health services.⁷ The 1963 Community Mental Health Act⁸ furthered this initiative by essentially altering the delivery of mental health services. Psychiatric medications were optimized and patients were assessed based on their ability to function in their social and occupational arenas; yet the number of psychiatrists decreased from 6.8% to 4.3%

than other health benefits, and few insurance plans cover providers' costs for implementing screening, care management, and other proactive services").

⁵ David Chorney, Note, *A Mental Health System in Crisis and Innovative Laws to Assuage the Problem*, 10 J. HEALTH & BIOMED. L. 215 (2014).

⁶ CHRIS KOYANAGI, HENRY J. KEISER FAMILY FOUNDATION, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM I (2007), available at https://www.google.com/url?url=http://www.nami.org/Template.cfm%3FSection%3DAbout_the_Issue%26Template%3D/ContentManagement/ContentDisplay.cfm%26ContentID%3D137545&rct=j&q=&esrc=s&sa=U&ved=0CB4QFjAAahUKEwj0u7n-nZfHAhXEEdR4KHdLIDAU&usg=AFQjCNEdcwjrDf_Ux5sieKaZ0XjvTzJ-3Q.

⁷ David Chorney, *supra* note 5, at 219.

⁸ Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 88 P.L. 164, 77 Stat. 282 (1963).

per community center.⁹ Eventually, the deinstitutionalization process fulfilled the ideal of releasing patients from locked institutions, but did not ensure adequate community-based mental health services.

Following deinstitutionalization, a number of problems ensued. Family members inherited the care of psychiatric patients. Furthermore, a high rate of incarceration occurred among those suffering from mental illness. These consequences were directly related to the lack of psychiatric care made available.¹⁰ Treatment was not growing at the rate and intensity needed to care for the number of individuals suffering from mental illnesses. The 1963 Community Mental Health Act succeeded at increasing knowledge behind the etiology of mental health, and promoting psychiatric research, yet funding was still very limited, causing patient care to suffer.¹¹

As a result, Medicaid began to absorb the cost of these patients. However, when the economy wanes, many hospitals and community health centers begin to deny patients covered under Medicaid, or these centers lose funding all together. The aforementioned patients often treat psychiatric emergency rooms as they would outpatient providers, or many self-medicate with alcohol or illegal substances, or the most severe may engage in illegal activities and find themselves in an over-crowded prison system. In fact, some of the largest providers of mental health care in the United States are correctional facilities. Consequently, the lack of unified structure resulted in patients being treated in a motley crew of facilities, such as nursing homes, homeless shelters, general

⁹ Gerald N. Grob, *Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health*, 83 *MILBANK Q.* 425, 427 (2005). This decline in the number of psychiatrists was recorded between the years of 1970 and 1975. *Id.*

¹⁰ See generally, Heather Boerner, *Mental Health Parity: Where It Has Been and Where It's Going*, *HEALTH CARE POL'Y*, Mar.-Apr. 2014, at 74- 76.

¹¹ *The Community Mental Health Act of 1963: Still Pursuing the Promise of Reform Fifty Years Later*, *YOUNG MINDS ADVOCACY PROJECT*, <http://www.youngmindsadvocacy.org/the-community-mental-health-act-of-1963/> (last visited Aug. 14, 2015).

hospitals, institutions and the like.¹²

The Carter Administration placed a renewed interest in mental health care, creating the President's Commission on Mental Health, which was given the complex role of recommending mental health programs for the country.¹³ The Commission developed the Mental Health Systems Act,¹⁴ which set out with goals to provide support for both mental health care, as well as after care within the community.¹⁵ Additionally, the Mental Health Systems Act provided federal grant funding to mental health promotion and advocacy programs for the rights of the mentally ill.¹⁶

The administrations of Ronald Reagan and George H. W. Bush detoured from the Mental Health Systems Act of Carter. Reagan approved the Omnibus Reconciliation Act of 1981,¹⁷ which was further supported throughout the administration of George H.W. Bush. This act redistributed the responsibility of mental health care from the federal level to the states' discretion.¹⁸ Under these administrations, the federal government would allocate grants to each state, leaving the governing body of the state to choose how these funds were then expended.¹⁹ The limitation in this program was related to the possible inability of each state to actually provide these

¹² Grob, *supra* note 9, at 428.

¹³ *Id.* at 428-30. See also A. Chamberlin, *Stop the Bleeding: a Call for Clarity to Achieve True Mental Health Parity*, 20 WIDENER L. REV. 253 (2014).

¹⁴ Mental Health Systems Act, 96 P.L. 398, 94 Stat. 1564 (1980).

¹⁵ Chamberlin, *supra* note 14.

¹⁶ President Jimmy Carter, Mental Health Systems Act Remarks, (Oct. 7, 1980), available at <http://www.presidency.ucsb.edu/ws/?pid=45228>.

¹⁷ Omnibus Reconciliation Act of 1981, Pub. L. 97-35, 95 Stat. 357 (1981). Congress subsequently passed the Mental Retardation Facilities Construction Act, Pub. L. 88-164, 77 Stat. 282 (1963).

¹⁸ CHRIS KOYANAGI, HENRY J. KEISER FAMILY FOUNDATION, LEARNING FROM HISTORY: DEINSTITUTIONALIZATION OF PEOPLE WITH MENTAL ILLNESS AS PRECURSOR TO LONG-TERM CARE REFORM 8 (2007), available at https://www.google.com/url?url=http://www.nami.org/Template.cfm%3FSection%3DAbout_the_Issue%26Template%3D/ContentManagement/ContentDisplay.cfm%26ContentID%3D137545&rct=j&q=&esrc=s&sa=U&ved=0CB4QFjAAahUKEwj0u7n-nZfHAhXEdR4KHdLIDAUsq=AFQjCNEDcwjrDf_Ux5sieKaZ0XjvTzJ-3Q.

¹⁹ Chamberlin, *supra* note 14, at 259-63.

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services. President Bill Clinton attempted to reconcile these limitations by proposing the Health Security Act in 1993,²⁰ which attempted to integrate mental and physical illnesses in an equal manner. However, these attempts were futile, as the mental health services section was limited, and the Bill never came to fruition.

The Mental Health Parity Act (MPA) of 1996²¹ was initially created to alter the distribution of mental health services, without penalizing patients for mental health conditions under the terms of coinsurance rates,²² hospitalization limits, and annual caps on care.²³ This act was the first attempt to create an equal opportunity for those afflicted with mental health conditions to acquire greater access to coverage. The term “parity” was rooted in the concept that individuals’ access to mental health care would be equal to that of their access to medical care.²⁴ However, the Mental Health Parity Act did not fulfill the ideal of true equality, as it was designed to do. For example, it did not require employers to provide mental health care, and substance abuse care was completely omitted.²⁵ As a result of this omission, a very high percentage of patients who are considered dual-diagnosis, thus suffering from both a mood or anxiety disorder and a form of addiction, were denied service. As of

²⁰ Jeffrey W. Koch, *Political Rhetoric and Political Persuasion: The Changing Structure of Citizens’ Preferences on Health Insurance During Policy Debate*, 62(2) PUB. OPINION Q. 209 (1998).

²¹ UNITED STATES DEP’T OF LAB., *Fact Sheet: Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)* (Jan. 29, 2010), <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

²² Coinsurance refers to the usage of two insurance carriers, one termed the primary insurance and the additional is termed the secondary insurance. The rationale for the development of coinsurance plans was to provide insurance for patients, without the necessity of paying out-of-pocket fees. The additional rationale for the carrying to two insurance plans was to optimize the providers’ opportunities for payment. However, coinsurance is more costly for the patient.

²³ UNITED STATES DEP’T OF LAB., *supra* note 21.

²⁴ R. Sturm, *How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?*, 278(18) J. AM. MED. ASS’N 1533 (1997).

²⁵ David Mechanic & Donna D. McAlpine, *Mission Unfulfilled: Potholes on the Road to Mental Health Parity*, 18(5) HEALTH AFF. 7 (1999). *See also* Chamberlin, *supra* note 14, at 258 (“the [legislation] was narrowed to affect only plans that already offered mental health coverage”).

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2002, approximately 4 million adults were diagnosed with a dual diagnosis.²⁶

The aforementioned deficits of the Mental Health Parity Act were addressed in the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008,²⁷ as the MPA expired in 2001, leaving considerable room for the inclusion of substance abuse and improvements in spending caps and deductibles.²⁸ The MHPAEA attempted to rectify the deficits of the MPA, by enacting several changes.²⁹ Firstly, under the MHPAEA, those companies who already offered mental health treatment were now required to offer this option in an equal rate of physical health services.³⁰ This means that the inclusion of mental health plans should be comparable in price to plans covering the traditional insurance plans. However, small employer plans, as well as plans that previously offered no mental health coverage, were neglected in the MHPAEA. Additionally, the definition of mental illness was left to be determined by the insurance company, or the state where the individual resided.³¹ This addition to the MHPAEA left a very large grey area for patients, as services may not be rendered, not because this individual does not carry a diagnosis, but because they are not diagnosed in the fashion the insurance company requires. Therefore, the MHPAEA provided the insurance company the ability to

²⁶ JENNY EPSTEIN, PEGGY BARKER, MICHAEL VORBURGER & CHRISTINE MURTHA, DEPARTMENT OF HEALTH AND HUMAN SERVICES, SERIOUS MENTAL ILLNESS AND ITS CO-OCCURRENCE WITH SUBSTANCE USE DISORDERS, 2002, 22-23 (June 2004) available at <http://www.ce-credit.com/articles/100995/CoD.pdf>. According to this source 23.2 percent of all adults diagnosed with a serious mental illness are also diagnosed with a substance use disorder. *Id.*

²⁷ See generally, Susan H. Busch, *Implications Of The Mental Health Parity And Addiction Equity Act*, 169 AM. J. PSYCHIATRY 1 (2012).

²⁸ Richard G. Frank, Kirsten Beronio & Sherry A. Glied, *Behavioral Health and the Affordable Care Act*, 13 J. SOC. WORK IN DISABILITY & REHABILITATION 31 (2014).

²⁹ Ford Kuramoto, *Affordable Care Act: Meeting the Health and Behavioral Needs of a Diverse Society*, 13 J. SOC. WORK IN DISABILITY & REHABILITATION 44 (2013).

³⁰ Chamberlin, *supra* note 14, at 259.

³¹ Robert Pear, *Equal Coverage for Mental and Physical Ailments is Required in Bailout Law*, NEW YORK TIMES, Oct. 6, 2008, at A13.

determine clinically essential treatment techniques, leading patients to be denied care based on a paper claim.³²

II. *Affordable Care Act*

The Patient Protection and Affordable Care Act (PPACA),³³ also known as Obamacare, was designed to fill the need for care that has been neglected throughout the history of healthcare in the United States.³⁴ The PPACA was designed to expand coverage of mental health and substance abuse/use disorder benefits at parity with medical coverage. Furthermore, the Act reached new frontiers in the areas of age restrictions, pre-existing conditions and the expansion of care.³⁵ Firstly, the PPACA expands coverage for children under their parents' plans until age twenty-six.³⁶ Additionally, the Act attempts to achieve parity by eradicating the concept of limits, both lifetime and annual, as well as preexisting conditions.³⁷ Lastly, the PPACA requires private insurance to cover "essential health benefits,"³⁸

³² *Id.*

³³ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

³⁴ Rachel L. Garfield, Judith R. Lave & Julie M. Donohue, *Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services*, 61(11) *PSYCHIATRIC SERVICES* 1081, 1081 (2010).

³⁵ *Id.*

³⁶ *AMCHP Issue Brief: The Affordable Care Act and Children and Youth with Autism Spectrum Disorder and Other Developmental Disabilities*, ASS'N OF MATERNAL AND CHILD HEALTH PROGRAMS 1, 4 (May 2012), http://www.amchp.org/Policy-Advocacy/health-reform/resources/Documents/ACA_AutismFactSheet_5-3-12.pdf.

³⁷ *Id.*

³⁸ Essential health benefits are considered a series of federal requirements, which must be met by qualified health insurance plans. These consist of ten categories of items and services required on all plans (i.e., individual and small group plans) participating in the Exchange. The PPACA's ten essential health benefits include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health services and addiction treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, wellness services, and chronic disease treatment; and pediatric services. However, specific health care benefits under each of the ten categories may vary by state.

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which are mandated by the Department of Health and Human Services.³⁹

However, the PPACA was not a completely novel concept. The roots of President Barack Obama's groundbreaking health care reform can be seen in his presidential competitor Mitt Romney's successful Massachusetts health and medical care reform. Romney's plan was signed into action in April 2006,⁴⁰ and subsequently created a health reform initiative characterized by an expansion of Medicaid, an affordable option for health care, and a required possession of health insurance, if one was able to afford and purchase it.⁴¹ Romney's plan was deemed a success, particularly because it extended coverage to 98.1% of adults and 99.8% of children in the state, which was the highest rate in the United States.⁴² Although the plans have significant differences, specifically in regards to taxpayers' responsibility, the parallels of affordable health insurance and earlier detection are clear.⁴³

In regards to mental health, Romney's plan displayed a strong argument for the efficient and successful recognition of mental health disorders. For example, one study revealed that following the initiation of statewide affordable insurance, the percentage of well-child visits using behavioral health screening instruments increased significantly.⁴⁴ This translates to the idea that earlier detection of mental health disorders leads to earlier treatment and potentially a

³⁹ Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL., POL'Y & L. 441 (2014).

⁴⁰ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

⁴¹ Charles J. Courtemanche & Daniela Zapata, *Does Universal Coverage Improve Health? The Massachusetts Experience*, 33 J. POL'Y ANALYSIS & MGMT. 36 (2014).

⁴² *RomneyCare – The Truth About Massachusetts Health Care*, MITTROMNEYCENTRAL.COM, <http://mittromneycentral.com/resources/romneycare> (last visited Aug. 14, 2015).

⁴³ *Id.*

⁴⁴ Giusy Romano-Clarke et al., *Have Rates of Behavioral Health Assessment and Treatment Increased for Massachusetts Children Since the Rosie D. Decision? A Report From Two Primary Care Practices*, 53(3) CLINICAL PEDIATRICS 243, 246 (2014).

shorter course of illness.

III. Why the United States was Ripe for the Passage of the Patient Protection and Affordable Care Act

According to the National Institute of Mental Health, during 2012 an estimated 43.7 million U.S. adults (18.6%) 18 years or older were diagnosed with any mental illness (AMI).⁴⁵ The National Survey on Drug Use and Health (NSDUH), conducted in 2008 by the Substance Abuse and Mental Health Services Administration (SAMHSA), defines any mental illness as: “a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders); diagnosable currently or within the past year; and of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.”⁴⁶ Furthermore, according to the National Survey on Drug Use and Health (NSDUH), 13.4% of adults in the United States received treatment for a mental or emotional health problem in 2008.⁴⁷

The NSDUH in 2008 reported that only 58.7% of adults in the United States diagnosed with a serious mental illness (SMI) received treatment for a mental health problem, of which 40.5% were outpatient services and 52.6% were prescription medication.⁴⁸ Given these statistics, it was imperative for national health care to identify and remove possible barriers to the provision of mental health services and treatment. In conjunction with musculoskeletal disorders, mental and behavioral disorders are regarded as the greatest contributors to the number of years lived with disability

⁴⁵ *Statistics: Any Mental Illness (AMI) Among Adults*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml> (last visited Aug. 14, 2015).

⁴⁶ *Id.*

⁴⁷ *Statistics: Use of Mental Health Services and Treatment Among Adults*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/use-of-mental-health-services-and-treatment-among-adults.shtml> (last visited Aug. 14, 2015).

⁴⁸ *Id.*

(YLD's) in the United States from 1990 to 2010.⁴⁹

Major depressive disorder, anxiety disorders, drug use disorders, Alzheimer's disease, alcohol use disorders, schizophrenia, bipolar disorder, and dysthymia rank among the top 20 diseases contributing to YLD's in the United States from 1990 to 2010.⁵⁰ Based on data obtained from SAMHSA in 2002, the NIMH estimated that total costs including expenses for mental health services and treatment (i.e., direct costs) and expenditures and losses associated with disability (i.e., indirect costs) caused by SMI, to be in excess of \$300 billion per year.⁵¹ As a result of the strain that mental illness places on workplace productivity and workers' health, employers support efforts targeted at expanding effective psychotherapeutic approaches, which may provide substantial improvements on an organization's productivity.⁵² Consequently, further understanding of the burden of mental health on the United States population and its impact on national health policy is warranted.

Given the increasing prevalence and costs of mental health disorders, countless health policy and legislative efforts have addressed concerns regarding access, efficiency and quality of mental health services. In response to these unmet needs, the PPACA was signed into law in 2008 and 2010. Through the Health Insurance Exchanges (HIE) and state-specific Medicaid expansions, approximately 50 percent of uninsured individuals will have access to health care coverage.⁵³

The PPACA requires individual and small-group health

⁴⁹ U.S. Burden of Disease Collaborators, *The State of US Health, 1990-2010: Burden of Diseases, Injuries, and Risk Factors*, 310(6) J. AM. MED. ASS'N 591 (2013).

⁵⁰ *Id.*

⁵¹ *Statistics: Annual Total Direct and Indirect Costs of Serious Mental Illness (2002)*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/cost/index.shtml> (last visited Aug. 14, 2015).

⁵² Patrick J. Kennedy, *Preface to Psychotherapy, the Affordable Care Act, and Mental Health Parity: Obstacles to Implementation*, 42(3) PSYCHODYNAMIC PSYCHIATRY 343, 344 (2014).

⁵³ Robyn L. Golden & Matthew R. Vail, *The Implications of the Affordable Care Act for Mental Health Care*, 38(3) J. AM. SOC. ON AGING 96, 96 (2014).

insurance plans to cover a minimum set of health benefit services that are deemed “essential.” Among these benefits, which include ambulatory care and prescription drugs, is the treatment of behavioral and mental health, as well as substance use disorders.⁵⁴ This expansion was considered a breakthrough in mental health treatment since it was “one of the largest expansions of mental health and substance use disorder coverage in a generation.”⁵⁵ The PPACA has the potential to provide grants for medication therapy management programs across the nation. This means that pharmacists, clinical pharmacologists, or health psychologists can counsel patients on their medications, including how to administer them and their possible side effects, in order to improve therapeutic outcomes.⁵⁶ Research has shown that medication management programs, especially for individuals diagnosed with schizophrenia, result in an increase of medication compliance.⁵⁷

Before the PPACA was enacted, Medicaid, Medicare, and other publicly funded community programs typically only covered the financial side of mental health treatment; private sectors usually covered a limited selection of services.⁵⁸ The PPACA also made it

⁵⁴ See Bagley & Levy, *supra* note 39; Jonathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL’Y 181 (2011).

⁵⁵ Kristen Beronio, Rosa Po, Laura Skopec & Sherry Glied, *ASPE Issue Brief: Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*, DEPT. OF HEALTH & HUMAN SERVICES 1 (Feb. 20, 2013), <http://aspe.hhs.gov/basic-report/affordable-care-act-expands-mental-health-and-substance-use-disorder-benefits-and-federal-parity-protections-over-62-million-americans>.

⁵⁶ *Issue Summary: Fund Medication Therapy Management Programs in the Patient Protection and Affordable Care Act*, AM. SOC’Y OF HEALTH-SYSTEM PHARMACISTS, <http://www.ashp.org/DocLibrary/Advocacy/MTM-Programs.aspx> (last visited Aug. 14, 2015).

⁵⁷ Thad A. Eckman, Robert P. Liberman, Catherine C. Phipps & Karen E. Blair, *Teaching Medication Management Skills to Schizophrenic Patients*, 10 J. CLINICAL PHARMACOLOGY 33, 37 (1990).

⁵⁸ *Health Reform and Mental Health*, NAT’L ALLIANCE ON MENTAL ILLNESS, http://www2.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Issue_Spotlights/Health_Care_Reform/ACA-FactSheet1_HealthReformMH.pdf.

possible for Americans to be guaranteed coverage by prohibiting insurance companies from denying affordable insurance to consumers with pre-existing conditions, including mental illnesses.⁵⁹

Nevertheless, mental health coverage in the PPACA has been criticized for its challenges. For starters, it is not yet nationally unified, as the magnitude of coverage still varies between and within states.⁶⁰ Also, individuals with mental health disorders are covered for a limited number of sessions and may encounter difficulties finding a therapist willing to accept their insurance. With limited funding, many of the provisions may never reach fruition.⁶¹ An exploration of the current trend in the application of PPACA in mental health settings and populations across the nation will now be discussed.

IV. Preventive Mental Health Care Goals

Title IV of the PPACA emphasizes the concept of disease prevention, by ensuring that Americans receive preventive services. Mental health services will be addressed, with the appropriate funding, in order to prevent chronic illnesses, obesity, suicide and substance addictions.⁶² However, many consumers are still unaware of these services, especially in regards to mental health. In fact, a survey conducted by the World Health Organization (WHO)⁶³ across the United States showed that most individuals with a mild psychiatric diagnosis of 12 months did not initiate treatment due to

⁵⁹ Allison W. Siegwarth & Chris Koyanagi, *The New Health Care Reform Act and Medicaid: New Opportunities for Psychiatric Rehabilitation*, 34(4) PSYCHIATRIC REHABILITATION J. 277 (2015).

⁶⁰ *Obamacare Essential Health Benefits: 10 Essential Health Benefits*, OBAMACARE FACTS, <http://obamacarefacts.com/essential-health-benefits/> (last visited Aug. 14, 2015).

⁶¹ Susan Brink, *Mental Health Now Covered Under ACA, but Not for Everyone*, U.S. NEWS & WORLD REPORT (Apr. 29, 2014).

⁶² Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

⁶³ L.H. Andrade et al., *Barriers to Mental Health Treatment: Results From the WHO World Mental Health Surveys*, 44(6) PSYCHOL. MEDICINE 1303, 1309 (2014).

low perceived need, while many of those with a higher perceived need believed that they could solve their illness on their own. On the other hand, individuals with severe psychiatric diagnoses did not initiate treatment due to structural barriers, including not knowing how to access treatment, inability to access treatment (i.e. travel), and cost. In addition, a large portion of individuals with mental health issues seek help from their primary care providers (PCPs) rather than mental health professionals. PCPs are actually the healthcare professionals who mostly prescribe antidepressant medications, as opposed to psychiatrists, who have received more training on the nature and efficacy of psychotropic medications.⁶⁴ Furthermore, the majority of individuals, particularly older adults, who commit suicide make contact with primary care providers at some point before, some even one month prior to their completed suicide.⁶⁵ These studies highlight the necessity for better mental health literacy in the United States, including the need to encourage mental health professionals and clinicians to better promote these services.

One of the goals of the PPACA is to prevent violent acts by individuals with mental illness and reduce crime rate by making mental health treatment more available.⁶⁶ For example, the PPACA has enacted plans to decrease the prevalence of gun violence in the U.S. The plans include training teachers on accurately identifying early signs of mental illness in students and referring them to the appropriate services.⁶⁷ As stated earlier, the PPACA will also ensure that all Americans are able to receive insurance for mental health treatment.⁶⁸ This preventive measure may alter the current trends in

⁶⁴ Ramin Mojtabai & Mark Olfson, *Proportion of Antidepressants Prescribed Without a Psychiatric Diagnosis is Growing*, 30(8) HEALTH AFF. 1434, 1436 (2011).

⁶⁵ Jason B. Luoma, Catherine E. Martin & Jane L. Pearson, *Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence*, 159(6) AM. J. PSYCHIATRY 909, 912 (2002).

⁶⁶ *Now is the Time: The president's plan to protect our children and our communities by reducing gun violence*, WHITE HOUSE 1, 9, 15 (Jan. 16, 2013), https://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf.

⁶⁷ *Id.* at 11-13.

⁶⁸ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

mental illness related to violence, given that approximately 90% of individuals released from local and county jails and detention centers are uninsured,⁶⁹ and 64% of incarcerated persons have some form of mental illness.⁷⁰ The number of jailed persons with mental illness has increased so dramatically over the past 15 years that the corrections system was labeled “the nation’s largest mental health provider.”⁷¹ This trend is largely due to a shortage of effective community mental health facilities and the lack of appropriate response to emergencies; a large number of individuals with mental illness are incarcerated during a relapse or crisis, rather than referred to mental health services.⁷² Currently, close to 35% of Chicago Cook’s County Jail population has some form of mental illness, making the jail the largest psychiatric hospital in the country.⁷³

Treating substance misuse early on may also prevent future crime rates. Substance abuse services are considered an “essential health benefit” under the PPACA. 80% of offenders abuse substances, nearly 50% of inmates have an addiction, and approximately 60% of individuals arrested for most types of crimes have tested positive for illegal drugs at arrest.⁷⁴ When comorbid with a mental illness, substance use, particularly alcohol, may be the

⁶⁹ Emily A. Wang et al., *Discharge Planning and Continuity of Health Care: Findings from the San Francisco County Jail*, 98 AM. J. PUB. HEALTH 2182 (2008).

⁷⁰ Doris J. James & Lauren E. Glaze, *Special Report: Mental Health Problems of Prison and Jail Inmates*, BUREAU OF JUSTICE STATISTICS 1 (2006).

⁷¹ John Fallon & Corrine Rearer, *The Corrections System Has Become the Nation’s Largest Mental Health Provider: Housing with Services is the Cost-Effective Solution*, 21 HOMELESS HEADLINES, (Feb. 2011) available at [http://www.law.uchicago.edu/files/file/HOMELESS%20HEADLINES_20110303161841%20\(2\)_0.pdf](http://www.law.uchicago.edu/files/file/HOMELESS%20HEADLINES_20110303161841%20(2)_0.pdf).

⁷² Taking Issue, *Jailing is Failing People With Mental Illness*, 60 PSYCHIATRIC SERVICES 723 (2009).

⁷³ Sy Mukherjee, *How Chicago’s Cook County Jail Became America’s Largest Mental Health Care Provider*, THINK PROGRESS (last updated July 12, 2013) available at <http://thinkprogress.org/health/2013/07/12/2293471/cook-county-jail-mental-health-provider/>.

⁷⁴ *Learn About Drugs: Drugs and Crime*, NAT’L COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC., <http://ncadd.org/learn-about-drugs/drugs-and-crime> (last visited Aug. 14, 2015).

trigger to violent crimes.⁷⁵ Under the PPACA, healthcare providers are able to treat patients with substance use problems more effectively using empirically-supported interventions. For example, the Brief Intervention and Referral to Treatment (SBIRT) is used to routinely screen for substance use in primary care settings and was designed for physicians to refer patients to appropriate services.⁷⁶ The researchers of the SBIRT have found good outcomes in preventing relapse.⁷⁷ In addition, chronic substance abuse sufferers are allowed continued care (by paying out-of-pocket) to improve long-term outcomes with the use of a Chronic Care Model (CCM), a treatment model utilizing social workers as providers.⁷⁸

When it comes to diagnosing and assessing for substance use, it is important for healthcare providers to avoid stigmatizing and stereotyping patients, as many patients may not feel comfortable sharing certain details.⁷⁹ Thus, clinicians must remain sensitive when approaching patients presenting with symptoms related to mental illness and substance addiction, so as not to deter them from receiving treatment.⁸⁰ Fortunately, through the use of scientifically sound brief interventions, such as Motivational Interviewing, healthcare providers can learn how to interact with their patients while retaining sensitivity.⁸¹

Another risk factor in crime-related activities is

⁷⁵ A.B. Wilson et al., *Examining the Impact of Mental Illness and Substance Use on Recidivism in a County Jail*, 34 INT'L J. OF L. AND PSYCHIATRY 264 (2011).

⁷⁶ Thomas F. Babor et al., *Screening, Brief Intervention, and Referral to Treatment*, 28(3) SUBSTANCE ABUSE 7, 8 (2007).

⁷⁷ Daniel J. Pilowsky & Li-Tzy Wu, *Screening for Alcohol and Drug Use Disorders Among Adults in Primary Care: A Review*, 3 SUBSTANCE ABUSE & REHABILITATION 25 (2012).

⁷⁸ Betty Tai & Nora D. Volkow, *Treatment for Substance Use Disorder: Opportunities and Challenges Under the Affordable Care Act*, 28 SOC. WORK IN PUB. HEALTH 165, 168, 170 (2013).

⁷⁹ C. Teutsch, *Patient-Doctor Communication*, 87 MED. CLINICS OF NORTH AMERICA 1115 (2003).

⁸⁰ Andrade et al., *supra* note 63, at 1312.

⁸¹ Sune Rubak, Anneli Sandbæk, Torsten Lauritzen & Bo Christensen, *Motivational Interviewing: A Systematic Review and Meta-Analysis*, 55 BRITISH J. OF GENERAL PRACTICE 305 (2005).

homelessness. 15.3% of jailed adults were homeless the year before their incarceration.⁸² Before implementation of the PPACA, low-income individuals were ineligible for Medicaid, which did not grant them access to mental health treatment, despite being involved in substance use-related legal complications. Even companies that aimed to assist the low-income groups experienced cuts in expenditures during the recession in the years 2009-2011.⁸³ As a result, one of the PPACA provisions is the expansion of coverage to all 18-65 year old individuals with incomes at or below 138% of the federal poverty level.⁸⁴ This means that low-income individuals will receive the supportive treatment that is necessary.

Depression and other mood disorder screening measures are also now available to all patients subsequent to the passage of the PPACA.⁸⁵ Screening Americans for these mental illnesses can potentially improve the nation's mental health, since depression affects approximately 9% of the population in the U.S., and accounts for \$43 billion in medical care costs.⁸⁶ In addition, similar to chronic health conditions, depression has a better quality of life outcome when diagnosed and treated early, further emphasizing the need to screen patients. When left untreated, depression can become a risk factor for a host of other problems in the future. One untreated major depressive episode can lead to further episodes, which then increases the risk of attempting suicide.⁸⁷ In addition, depression is often comorbid with other mental illnesses, such as substance use and

⁸² Greg A. Greenberg & Robert A. Rosenheck, *Jail Incarceration, Homelessness, and Mental Health: A National Study*, 59(2) PSYCHIATRIC SERVICES 170, 170 (2008).

⁸³ Harold Pollack, *Reality-Based Mental Health Reform*, WASHINGTON MONTHLY, Apr. 2013 available at http://www.washingtonmonthly.com/magazine/march_april_2013/features/realitybased_mental_health_ref043313.php?page=all.

⁸⁴ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

⁸⁵ *Id.*

⁸⁶ Douglas M. Maurer, *Screening for Depression*, 85(2) AM. FAM. PHYSICIAN 139 (2012).

⁸⁷ H. A. Whiteford et al., *Estimating Remission from Untreated Major Depression: A Systematic Review and Meta Analysis*, 43 PSYCHOL. MED. 1569 (2013).

anxiety disorders; treating depression effectively in these patients can lead to improvements in the comorbid illnesses.⁸⁸ Epidemiological studies have also linked depression to poor health.⁸⁹ Depression has been linked to chronic diseases such as diabetes, angina, arthritis, and asthma.⁹⁰

Behavioral health professionals specializing in the medical field, such as health psychologists, will also treat chronic medical illnesses with preventive measures based in psychological interventions. An example of this is the provision of counseling and behavioral interventions to children and families suffering from obesity. This has the potential of becoming a monumental change in the future health of the United States with the current trends in childhood obesity. The prevalence of childhood obesity in the United States in 2011-2012 was 16.9%,⁹¹ ranking as the fourth country in the world with the most overweight or obese children.⁹² Adequate preventive measures lead to healthier children, and thus reduces the risk of future chronic medical illnesses, such as hypertension.⁹³

Sexually transmitted infections (STIs) are also among the public health concerns in the United States. Approximately half of Americans will contract an STI at some point in their lifetime, less than half of those between the age of 18 and 44 have been tested for STIs other than HIV.⁹⁴ Under the PPACA, sexually active

⁸⁸ D. S. Hasin, R.D. Goodwin, F. S. Stinson & B. F. Grant, *Epidemiology of Major Depressive Disorder: Results from the National Epidemiologic Survey on Alcoholism and Related Conditions*, 62 ARCHIVES GEN. PSYCHIATRY 1097 (2005).

⁸⁹ Saba Moussavi et al., *Depression, Chronic Diseases, and Decrements in Health: Results From the World Health Surveys*, 370 LANCET 851 (2007).

⁹⁰ F. Rotella & E. Mannucci, *Depression as a Risk Factor for Diabetes*, 74 J. CLINICAL PSYCHIATRY 31 (2013).

⁹¹ Cynthia L. Ogden, Margaret D. Carroll, Brian K. Kit & Katherine M. Flegal, *Prevalence of Childhood and Adult Obesity in the United States, 2011-2012*, 311(8) J. AM. MED. ASS'N 806, 808 (2014).

⁹² ORG. FOR CO-OPERATION AND ECON. DEV., OBESITY UPDATE, 4 (June 2014).

⁹³ See generally Pernilla Danielsson, Jan Kowalski, Örjan Ekblom & Claude Marcus, *Response of Severely Obese Children and Adolescents to Behavioral Treatment*, 166 ARCHIVES PEDIATRIC & ADOLESCENT MED. 1103 (2012).

⁹⁴ *Statistics on Sexually Transmitted Infections*, REQUEST A TEST (Apr. 1, 2014), <http://requestatest.com/statistics-on-sexually-transmitted-infections-140401>.

adolescents and adults obtain the right to receive high-intensity behavioral counseling to prevent contacting and spreading STIs.⁹⁵ Consumers will be covered for a maximum of two individual 20-30 minute counseling sessions when referred by a PCP.⁹⁶ Counselors who utilize empirically-supported interventions, such as the Comprehensive Risk Counseling and Services (CRCS)⁹⁷ achieve positive results in reducing the risk of patients either acquiring or spreading STIs. Therefore, with adequate promotion to at-risk populations, a large number of Americans may be prevented from acquiring an STI.

V. *Mental Health Care for Special Populations*

A. *Veterans*

The PPACA was also formulated to assist those individuals that are part of particular populations, who may have been overlooked under past legislation. Veterans, for example, typically receive free or low-cost services from the U.S. Department of Veteran Affairs (VA) health care. However, 86.9% of veterans do not utilize VA healthcare because they are either not enrolled or ineligible to receive the services.⁹⁸ Multiple reasons for these veterans not utilizing VA services have been cited, such as not realizing they are eligible, delaying or avoiding seeking medical care, having lower health care need, and being in transient or homeless status that makes it difficult for them to reach the services

⁹⁵ Medicare National Coverage Determinations, CENTERS FOR MEDICARE & MEDICAID SERVICES, Pub. 100-03, § 210.10, (Jan. 26, 2012), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf.

⁹⁶ *Id.*

⁹⁷ For a description of this counseling, Healthy Living Project Team, *Effects of a Behavioral Intervention to Reduce Risk of Transmission Among People Living with HIV: The Healthy Living Project Randomized Controlled Study*, 44(2) J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 213 (2007).

⁹⁸ Karin M. Nelson, Gordon A. Starkebaum & Gayle E. Reiber, *Veterans Using and Uninsured Veterans Not Using Veterans Affairs (VA) Health Care*, 122 PUB. HEALTH REP. 93, 95 (2007).

they need.⁹⁹ As a result, the VA network has been restructured in order to attempt to make services accessible for veterans.¹⁰⁰ There is currently no data regarding the number of uninsured veterans affected by the PPACA, though analyses have revealed that over half of the aforementioned veterans may be eligible for coverage under the expansion.¹⁰¹ Nevertheless, some veterans may remain uninsured if they live in states that do not implement expansion to a certain poverty level.¹⁰² Additionally, veterans that require more extensive health needs than the VA can provide may not receive the needed level of care, thus the PPACA might be a viable and potentially encouraging option for them.¹⁰³

B. Women

The PPACA provides women and children who were victims of abuse access to services related to the aforementioned violence, as well as economic support for life after the event(s).¹⁰⁴ Treatment for this population includes couples counseling and training. Additionally, clinicians will routinely screen for intimate partner violence and will conduct home-based domestic violence risk assessments.¹⁰⁵ From a preventative approach, educational programs are being implemented to reduce the risk of unintended teen pregnancies, which have been linked to future incidences of domestic

⁹⁹ *Id.* at 122.

¹⁰⁰ M.K. Chapko et al., *Evaluation of the Department of Veterans Affairs Community-Based Outpatient Clinics*, 40 *MED. CARE* 555 (2002). *See also* Nelson, Starkebaum & Reiber, *supra* note 98, at 97.

¹⁰¹ Jack Tsai & Robert Rosenheck, *Uninsured Veterans Who Will Need to Obtain Insurance Coverage Under the Patient Protection and Affordable Care Act*, 104 *AM. J. PUB. HEALTH* e57 (2014).

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ FUTURES WITHOUT VIOLENCE, *How the Affordable Care Act (ACA) Affects Victims of Domestic, Sexual, and Dating Violence* 1, 1 <http://www.healthcaresaboutipv.org/wp-content/blogs.dir/3/files/2012/09/ACA-and-DV-final.pdf> (last updated June 2012).

¹⁰⁵ *Id.*

violence.¹⁰⁶

C. *Elderly Adults*

Older adults are among one of the fastest growing age groups, so it is no surprise that there is an increased need for treatment within this population. President Obama aims to maintain both Social Security and Medicare programs, as they have been tremendously supportive in the care of older adults. The PPACA strengthens programs for older adults by cutting consumer costs, protecting them from fraud, and providing easily understood comparisons of prescription drug plans.¹⁰⁷ Family caregivers and direct care practitioners (such as case managers, social workers, and nurses) will also receive adequate training and resources, as they are considered to be part of the geriatric patient's treatment.¹⁰⁸

D. *Children and Adolescents*

Children, adolescents, and young adults (ages 18-25) are at great risk of insufficient or complete lack of health insurance.¹⁰⁹ Behavioral health clinicians are a crucial asset for this population, specifically regarding behavior change for key issues such as obesity, substance use, depression, and sexually transmitted diseases.¹¹⁰ With that stated, the PPACA provides emotional screenings as part of

¹⁰⁶ *Id.* at 2.

¹⁰⁷ Jeanne M. Sorrell, *The Obama Health Care Plan: What it Means for Mental Health Care of Older Adults*, 47 J. PSYCHOSOCIAL NURSING 21, 23 (2009).

¹⁰⁸ *Geriatric-friendly resources in the Affordable Care Act*, AM. GERIATRICS SOC. http://www.americangeriatrics.org/files/documents/Adv_Resources/Geri-Friendly.Provisions.ACA.pdf (last visited Aug. 14, 2015).

¹⁰⁹ Michael E. Martinez & Robin A. Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-June 2011*, CENTER FOR DISEASE CONTROL, (Dec. 2011), available at <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201112.pdf>.

¹¹⁰ See generally Tina Paul Mulye et al., *Trends in Adolescent and Young Adult Health in the United States*, 45 J. ADOLESCENT HEALTH 8 (2009).

routine preventive services.¹¹¹ These preventive emotional screenings were formulated in response to the recent violent outbreaks, such as the Columbine High School Massacre and the 2011 Tucson shooting, where Representative Gabrielle Giffords was wounded,¹¹² which researchers believe could have been prevented with the increased use of risk assessment and behavioral interventions.¹¹³

Children in foster systems and with developmental disabilities, such as those who function in the Autism spectrum of disorders, are also eligible for the expansion, and will benefit from an end of the lifetime coverage cap.¹¹⁴ This is particularly beneficial and of great assistance to those children and adolescents receiving Applied Behavior Analysis therapy,¹¹⁵ the empirically validated treatment technique for autism, and autism spectrum disorders.

Under the PPACA, children can remain on their parents' insurance until age 26, an increase from the previous cut-off of age 18.¹¹⁶ This expansion has the potential to serve more individuals during vulnerable times. Three fourths of 9,282 individuals surveyed with the DSM-IV, the American Psychiatric Association's classification and diagnostic tool, were diagnosed with a psychiatric illness by age 24.¹¹⁷ Appropriate intervention during the early stages of a disorder, especially at the onset, has the possibility of reducing illness severity and/or persistence and preventing secondary disorders.¹¹⁸

¹¹¹ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

¹¹² *Now is the Time*, *supra* note 66.

¹¹³ See generally Kristin D. Eisenbraun, *Violence in Schools: Prevalence, Prediction, and Prevention*, 12 AGGRESSION & VIOLENT BEHAVIOR 459 (2007).

¹¹⁴ *AMCHP Issue Brief*, *supra* note 36.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593 (2005).

¹¹⁸ Patrick D. McGorry, Rosemary Purcell, Sherilyn Goldstone & G. Paul Amminger, *Age of Onset and Timing of Treatment for Mental and Substance Use Disorders: Implications for Preventive Intervention Strategies and Models of Care*, 24 CURRENT OP. IN PSYCHIATRY 301 (2011).

Another population that will benefit from the expansion are those with a diagnosis related to an eating disorder. The majority of individuals with this diagnosis are females in late adolescence.¹¹⁹ The PPACA will assist these individuals by ensuring they receive an unlimited number of sessions to treat this conditions, which often bridges both medical and psychiatric concerns.¹²⁰ Cognitive behavioral therapy provided during post-hospitalization was shown to be significantly more effective than nutritional counseling regarding outcome improvement and relapse prevention.¹²¹

E. Native Americans

The PPACA reauthorized the Indian Health Care Improvement Act, which “extends current law and authorizes new programs and services within the Indian Health Service.”¹²² This includes the continued use of tribal and urban Indian health programs, and access to coverage through Medicare, Medicaid, and the Children’s Health Insurance Program. Essentially, Native Americans will have more access to affordable health coverage in order to receive preventive and wellness healthcare services, which are consistent with their cultural values and norms.¹²³

VI. Disadvantages of the Patient Protection and Affordable Care Act

Healthcare reform has provided multiple advantages for mental health and substance abuse services through the Patient

¹¹⁹ Frédérique R. E. Smink, Daphne van Hoeken & Hans W. Hoek, *Epidemiology of Eating Disorders: Incidence, Prevalence and Mortality Rates*, 14 CURRENT PSYCHOL. REP. 406 (2012).

¹²⁰ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

¹²¹ Kathleen Pike et al., *Cognitive Behavior Therapy in the Posthospitalization Treatment of Anorexia Nervosa*, 160 AM. J. PSYCHIATRY 2046, 2047 (2003).

¹²² *The Federal Health Program for American Indians and Alaska Natives*, INDIAN HEALTH SERVICE, <http://www.ihs.gov/aca/> (last visited Aug. 15, 2015).

¹²³ Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2014).

Protection and Affordable Care Act mental health parity. Nevertheless, such benefits are accompanied by several shortcomings. One disadvantage presented by the PPACA pertains to the 190-day lifetime limit on inpatient admissions to psychiatric units, which greatly affects patients diagnosed with chronic and serious psychiatric illnesses requiring recurrent treatment.¹²⁴ It is important to note that such limitation does not apply to any other type of inpatient service,¹²⁵ which supports the already existing inequality between physical and mental health care coverage.

Shortage of psychiatrists and inadequate reimbursement rates by insurers has prompted another barrier to adequate treatment as “only 54.8 percent of psychiatrists accepted Medicare [versus] 86.1 percent [of] other specialists.”¹²⁶ This would reduce the geriatric population’s ease of access to limited mental health services. Mental health reform alone is unable to eliminate the prevailing fear and stigma associated with psychiatric illness; however, increasing efforts to refrain from judgment of others’ behavior may contribute in decreasing such fear and stigma.¹²⁷

Another gap in coverage regards the accessibility of mental health services for immigrants, given that they do not qualify for public health programs and are unable to purchase insurance from the Health Insurance Exchanges.¹²⁸ It is also of interest to address the universality of the PPACA, as it is constantly questioned due to a lack of clear definitions regarding the proposed essential health benefits. As the provision of specialized services and treatments is determined at a state instead of a national level, this results in a disparity of healthcare services between states. Scarcity of mental health providers and implications for treatment are expanded further in the following sections.

According to SAMHSA, in approximately five years, mental

¹²⁴ Golden & Vail, *supra* note 53.

¹²⁵ *Id.*

¹²⁶ *Id.* Boerner, *supra* note 10, at 76.

¹²⁷ Susan L. Dahline, *Mental Health Parity: Closing the Gaps*, J. PENSION BENEFITS 38, 41 (2013).

¹²⁸ Golden & Vail, *supra* note 53, at 99.

and substance use disorders will become more prevalent than physical illnesses as a major source of disability worldwide.¹²⁹ Therefore, national mental and physical illness prevention models must be reformed with the aim of achieving a primary instead of a tertiary prevention model.¹³⁰ A primary prevention model would allow for the early detection of mental and physical illnesses, resulting in a decrease in the incidence, prevalence, progression, and costs of these illnesses. It is important to note that characteristic behaviors and symptoms suggesting the onset of a behavioral disorder emerge approximately two to four years before the onset of the disorder itself.¹³¹

This is exemplified among individuals diagnosed with substance use disorders, given that they are increasingly more vulnerable to mental disorders and physical health problems, which may require longstanding treatment.¹³² Consequently, screening and early intervention for behavioral disorders within primary care settings, would prevent the progression of behavioral problems into serious mental illness as well as the development of comorbid chronic physical illnesses.¹³³ What role does PPACA play in the prevention of mental illness progression and mitigation of early onset symptoms?

The PPACA law developed a Prevention and Wellness Trust, which centered on the funding of prevention activities and development of a national prevention and wellness strategy.¹³⁴ In addition, the federal government is required to conduct reviews of

¹²⁹ *Prevention of Substance Abuse and Mental Illness*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN. (SAMHSA), <http://www.samhsa.gov/prevention> (last updated Sept. 29, 2014).

¹³⁰ For more on the difference between these models, see *What Researchers Mean by . . . Primary, Secondary and Tertiary Prevention*, INST. FOR WORK & HEALTH, available at <http://www.iwh.on.ca/wrmb/primary-secondary-and-tertiary-prevention> (last visited Aug. 14, 2015).

¹³¹ *Prevention of Substance Abuse and Mental Illness*, *supra* note 129.

¹³² Tai & Volkow, *supra* note 78, at 166.

¹³³ *Id.*

¹³⁴ CHRIS KOYANAGI & ALLISON W. SIEGWARth, HOW WILL HEALTH REFORM HELP PEOPLE WITH MENTAL ILLNESSES?, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW 1, 7 (2010).

current preventive strategies and implementation at the community level.¹³⁵ Development of preventive national strategies centered on mental health is headed by SAMHSA. According to SAMHSA, early intervention and coordinated, specialized services following the first episode of a serious mental illness are determining factors for improving clinical and functional outcomes as it reduces unemployment, homelessness, poverty and suicide rates.¹³⁶ SAMHSA proposes a comprehensive approach to mental health treatment through the conceptualization of prevention as a component of overall continuum of care.¹³⁷

The Behavioral Health Continuum of Care Model was based on the 1994 Mental Health Intervention Spectrum and is comprised of the following components: promotion, prevention, treatment and recovery. Rooted in this model of care, SAMHSA has developed several programs related to prevention and early intervention including Strategic Prevention Framework (SPF),¹³⁸ Project Advancing Wellness and Resilience in Education (AWARE),¹³⁹ Healthy Transitions,¹⁴⁰ and Minority AIDS Initiative (MAI)¹⁴¹

¹³⁵ *Id.*

¹³⁶ *Prevention of Substance Abuse and Mental Illness*, *supra* note 129.

¹³⁷ *Id.*

¹³⁸ The Strategic Prevention Program (SPF) implements findings obtained from public health research and evidence-based prevention programs as a means of developing sustainable prevention. The SPF entails a five-step planning process that serves as guidance for the selection, implementation, and evaluation of effective prevention efforts; which promote resilience and decreases risk factors among individuals, families, and communities.

¹³⁹ Project Advancing Wellness and Resilience in Education (AWARE) was developed in an effort to increase awareness of mental health issues and provide adequate referrals to individuals and families in need of behavioral health treatment services. Such project is comprised by State Grants and Mental Health First Aid (MHFA), which attempt to prevent violence and increase access to mental health services through the creation of safe and supportive schools and communities. Moreover, the project provides training to teachers and other adults to identify and respond to mental illness among children and youth. *See SAMHSA's Efforts Related to Prevention and Early Intervention: Project AWARE*, SAMHSA, <http://www.samhsa.gov/prevention/samhsas-efforts> (last updated Jan. 13, 2015).

¹⁴⁰ Healthy Transitions program strives to expand access to mental health services for youth and young adults (i.e., 16 to 25 years of age) who are vulnerable

among others.¹⁴² Nevertheless, it is important to note that effective implementation requires preventive strategies to be tailored to the risk and protective factors, cultural context and needs of each community and population.¹⁴³ Through the implementation of the PPACA, coverage of preventive services has expanded enabling the application of screening, brief intervention and referral to treatment among different clinical settings and in turn, reducing the development or exacerbation of serious mental illness.

VII. What Does This Mean for Florida?

According to Koyanagi and Siegwarth, Medicaid is a better option than a private insurance plan regarding the provision of mental health services.¹⁴⁴ This is evidenced by a wider scope of community services centered on recovery, skills training, employment-related services and supported housing, therapy and medications.¹⁴⁵ Nevertheless, prior to the implementation of the PPACA, Medicaid was intended to serve the needs of adults with significant disabilities or caretakers of children.¹⁴⁶ Therefore, the PPACA expanded Medicaid eligibility to include coverage to

or diagnosed with a serious mental illness and/or substance use disorder. See *SAMHSA's Efforts Related to Prevention and Early Intervention: Healthy Transitions*, SAMHSA, <http://www.samhsa.gov/prevention/samhsas-efforts> (last updated Jan. 13, 2015).

¹⁴¹ Minority AIDS Initiative (MAI) attempts to improve access to HIV and substance use prevention services among at-risk minority populations through the implementation of integrated, evidence-based substance use and HIV preventative interventions. See *SAMHSA's Efforts Related to Prevention and Early Intervention: Minority AIDS Initiative (MAI)*, SAMHSA, <http://www.samhsa.gov/prevention/samhsas-efforts> (last updated Jan. 13, 2015).

¹⁴² See generally, *SAMHSA's Efforts Related to Prevention and Early Intervention*, SAMHSA, <http://www.samhsa.gov/prevention/samhsas-efforts> (last updated Jan. 13, 2015)

¹⁴³ Mary W. Murimi & Tammy Harpel, *Practicing Preventive Health: The Underlying Culture Among Low-Income Rural Populations*, 26 J. RURAL HEALTH 273, 274 (2010).

¹⁴⁴ KOYANAGI & SIEGWARTH, *supra* note 134, at 2.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* at 3.

everyone with an income below 133% of the federal poverty level, effective in 2014.¹⁴⁷

However, coverage under the new Medicaid expansion varied among individuals. Children and families are eligible for full Medicaid coverage, while adults with income below 133% of poverty could be eligible for a more limited benchmark benefit.¹⁴⁸ According to the PPACA, if limited benchmark benefits are provided these must at least, include the same essential health benefits (EHB) established by the PPACA law for health insurance plans obtained through the Health Insurance Exchanges.¹⁴⁹ Limited benchmark benefits would have significant implications for individuals with psychiatric disabilities, given that access to rehabilitation and recovery-focused services is lacking, while the individuals are only eligible for inpatient hospital care and outpatient medications and therapy.¹⁵⁰

Deficient provision of mental health services among individuals with psychiatric disabilities was attributed to the strict qualifications for Medicaid for which the psychiatric population failed to qualify or chose not to apply.¹⁵¹ The majority of individuals diagnosed with a psychiatric illness are not eligible for disability benefits. Therefore, through the elimination of the federal Supplemental Security Income (SSI) disability benefit as a requirement for Medicaid coverage among individuals with incomes below 133% of the poverty level, health care coverage becomes accessible to the psychiatric population.¹⁵²

Among the ten essential health benefits (EHB) established by the PPACA, mental health and substance abuse disorders and behavioral health treatment are included.¹⁵³ However, according to

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ KOYANAGI & SIEGWARTH, *supra* note 134, at 3.

¹⁵¹ *Id.*

¹⁵² *Id.* at 4.

¹⁵³ Sarah Hewitt, *A Time to Heal: Eliminating Barriers to Coverage for Patients with Eating Disorders Under the Affordable Care Act*, 31 *LAW & INEQUALITY* 411, 413 (2013).

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the plan designed by the Department of Health and Human Services, each state is allowed to choose a benchmark plan from a list of several existing options in that state. Therefore, coverage for specific mental health services may be significantly limited or excluded as determined by the benchmark plan adopted by each state.¹⁵⁴ This may lead to uncertainty regarding the universality of the PPACA, given that mental health parity laws differ by state.

Regarding the State of Florida, *Blue Cross and Blue Shield of Florida – Blue Options* was chosen as the EHB Benchmark Plan.¹⁵⁵ Concerning mental health coverage, the following benefits are offered: mental/behavioral health outpatient services are covered 20 visits per year, mental/behavioral health inpatient services are covered 30 days per year, and substance abuse disorder outpatient/inpatient services are covered without quantitative limits.¹⁵⁶ However, certain exclusions apply to mental/behavioral health outpatient and inpatient services. These exclusions include:

Services for psychological testing associated with the evaluation and diagnosis of learning disabilities; marriage counseling; pre-marital counseling; court-ordered care or testing, or required as a condition of parole or probation; testing of aptitude, ability, intelligence or interest; evaluation for the purpose of maintaining employment inpatient confinement or inpatient mental health services received in a residential treatment facility.¹⁵⁷

Furthermore, even though Medicaid expansion falls under the PPACA, state legislators have the option of refusing such expansion.¹⁵⁸ Florida is among the group of states that refused

¹⁵⁴ *Id.*

¹⁵⁵ Florida EHB Benchmark Plan, CENTER FOR MED. SERVICES 1, 4 (2014), available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/florida-ehb-benchmark-plan.pdf>.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 5.

¹⁵⁸ Daniel Chang, *Florida Hospitals Could Lose Billions Without Medicaid Expansion, Group Warns*, MIAMI HERALD, Nov. 10, 2014, <http://www.miamiherald.com/news/local/community/miami-dade/article3727590>.

Medicaid expansion.¹⁵⁹ Consequently, this entails several implications for the mental health treatment of the uninsured, or individuals below the poverty level. Through the Medicaid Disproportionate Share Hospital Program (DSH) additional financial support was provided to hospitals that serve a high rate of uninsured patients.¹⁶⁰ However, after the expansion of Medicaid coverage under the PPACA, the DSH funding was significantly reduced given that through Medicaid reform the number of uninsured individuals would be significantly reduced.¹⁶¹

These reductions in funding have no implications for states that have expanded their Medicaid coverage in accordance with the PPACA law; however, it represents adverse fiscal implications for states like Florida, that refused Medicaid expansion.¹⁶² Such refusal has left approximately 764,000 Floridians uninsured under Medicaid coverage.¹⁶³ The largest number of low-income uninsured individuals is found in Miami-Dade County.¹⁶⁴ Therefore, hospitals in the Miami-Dade area, which receive the greatest amount of DSH funding, would experience the most shortcomings with these reductions.

The Chief Executive Officer of Jackson Memorial Hospital, Mr. Carlos Migoya, explained the negative implications the hospital would endure due to the state's refusal to implement Medicaid expansion. As the largest healthcare provider of uninsured individuals in the Miami-Dade area, Jackson Memorial Hospital could stand to lose approximately \$570 million per year.¹⁶⁵ While hospitals in Broward, Palm Beach, and Monroe counties could lose

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¹⁵⁹ *Id.*

¹⁶⁰ Charlotte Joseph Cassel & Miriam Harmatz, *Federal funding for coverage of Florida's uninsured is critical to offset county and safety-net health provider losses*, FLORIDA LEGAL SERVICES 1, 3 (Nov. 10, 2014), <http://www.miamiherald.com/news/local/community/miami-dade/article3727588.ece/BINARY/Read%20the%20Florida%20Legal%20report>.

¹⁶¹ *Id.* at 3

¹⁶² *Id.*

¹⁶³ *Id.* at 4

¹⁶⁴ *Id.*

¹⁶⁵ Chang, *supra* note 158.

more than \$500 million in annual federal funding.¹⁶⁶ In other words, Miami-Dade cannot afford for Medicaid expansion to not be implemented as a non-profit hospital system such as Jackson Memorial Hospital relies on local, state, and federal funding to maintain operation.¹⁶⁷

In an effort to account for the gap in coverage of mental health services resulting from a refusal to implement Medicaid expansion, Florida was the first state to offer a Medicaid health plan developed specifically for individuals with serious mental illness. The plan is offered by a subcontractor identified as Magellan Complete Care, which aims to coordinate physical and mental health care for individuals enrolled in Medicaid as comorbidity between both types of illnesses account for a significant proportion of Medicaid spending.¹⁶⁸

VIII. Provider Implications

One of the impacts of the PPACA on mental health pertains to the significant increase in mental health and substance abuse treatment since 2011, as coverage for mental health treatment has expanded. During 2011, substance abuse and mental health admissions experienced a 20 and 6 percent increase, respectively among individuals younger than 65 years of age.¹⁶⁹ Moreover, from 2011 to 2013, mental health and substance use admission rates have remained stable.¹⁷⁰ This could be a result of the implementation of the PPACA, which has expanded accessibility of mental health

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ Phil Galewitz, *Florida Becomes First State to Implement New Mental Health Strategy*, KAISER HEALTH NEWS (July 7, 2014), http://www.huffingtonpost.com/2014/07/07/florida-medicaid-mental-health_n_5563835.html

¹⁶⁹ Beth Braverman, *6 Ways Obamacare is Changing Mental Health Coverage*, FISCAL TIMES (Nov. 26, 2013) <http://www.fiscaltimes.com/Articles/2013/11/26/6-Ways-Obamacare-Changing-Mental-Health-Coverage>.

¹⁷⁰ 2013 HEALTH CARE COST AND UTILIZATION REPORT, HEALTH CARE COST INST. 1, 8 (Oct. 2014), *available at* <http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report>.

services including preventive measures allowing for the early detection of mental health illness and decreasing psychiatric admissions. Antidepressants represent the highest per capita spending on prescriptions during 2013, exhibiting a continuous increase since 2009.¹⁷¹ As mentioned above, Major Depressive Disorder represents one of the top 20 diseases contributing to disability among the U.S. population.¹⁷² In addition, psychotropic medication represents one of the preferred outpatient treatments for depressive disorders and increased accessibility to such medications through the PPACA could account for the increase in antidepressant spending.¹⁷³

Expansion of mental health coverage through the PPACA has exacerbated the scarcity of psychiatric hospitals and services, given that more individuals are currently seeking mental health treatment.¹⁷⁴ According to Braverman, only 53 percent of mental health demands are met by psychiatrists due to decreased availability of providers in the field.¹⁷⁵ The proportion of the population whose mental health services are adequately covered will have decreased approximately 21 to 24 percent in 2014 as 62.5 million individuals become eligible for mental health services under the PPACA.¹⁷⁶ Consequently, the emerging concern relates to an increasing number of individuals seeking mental health and substance abuse services, however, these services are strained due to diminished availability of psychiatric providers.¹⁷⁷

Psychiatrists, psychologists, social workers, psychiatric mental health nurse practitioners and specialists, and licensed

¹⁷¹ *Id.* at 21.

¹⁷² U.S. Burden of Disease Collaborators, *supra* note 49.

¹⁷³ 2013 HEALTH CARE COST AND UTILIZATION REPORT, *supra* note 170, at 26.

¹⁷⁴ Shoshannah A. Pearlman, *The Patient Protection and Affordable Care Act: Impact on Mental Health Services Demand and Provider Availability*, 19 J. AM. PSYCHIATRIC NURSES ASS'N 327 (2013).

¹⁷⁵ Braverman, *supra* note 169.

¹⁷⁶ Pearlman, *supra* note 174, at 328.

¹⁷⁷ Jeffrey A. Buck, *The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act*, 30 HEALTH AFF. 1402 (2011). *See also* Pearlman, *supra* note 189.

professional counselors are among the different categories of mental health and substance abuse treatment providers available to care for this growing population. However, providers with prescriptive authority (i.e., psychiatrists and psychiatric mental health nurse practitioners) represent the largest gap in mental health services.¹⁷⁸ Several recommendations have been proposed to meet the increasing needs of the psychiatric population. It has been suggested that mental health services should be incorporated in primary mental health care settings through encouragement of coordinated care among psychologists, psychiatrists, and psychiatric mental health nurse practitioners.¹⁷⁹

Such emphasis on coordinated care is promoted by the PPACA through the development of Accountable Care Organizations (ACO's)¹⁸⁰ and patient-centered medical homes,¹⁸¹ which provide integrated care for mental health and chronic physical conditions.¹⁸² According to the PPACA, the aim of these organizations is to improve outcomes and decrease costs. Furthermore, ACO programs have already been implemented in locations such as Montefiore Medical Center Bronx, New York and Chicago, Illinois.¹⁸³ The effectiveness and quality of care of these programs is evidenced by the \$14 million in savings for Montefiore Medical Center and implementation of a 24-hour psychiatric

¹⁷⁸ Pearlman, *supra* note 174, at 328.

¹⁷⁹ Debra S. Nault, *Mental Health: The Current Crisis and What Nurses Must Know*, MICHIGAN NURSES ASS'N, 16, 20 (2013).

¹⁸⁰ Accountable Care Organizations (ACO's) are responsible for providing incentives to doctors, hospitals, and other health care programs for the development of coordinated care

¹⁸¹ Patient-Centered Medical Homes (PCMH) is considered a widely accepted model for how primary care should be organized and delivered. Such homes are designed to aid in the coordination of primary and acute physical health services, behavioral healthcare, and long-term community-based services. For more on these services, *see generally* Leiyu Shi, *The Impact of Primary Care: A Focused Review*, 2012 SCIENTIFICA 1 (2012), available at <http://www.hindawi.com/journals/scientifica/2012/432892/>.

¹⁸² Boerner, *supra* note 10, at 76.

¹⁸³ *Id.*

telemedicine program for emergency rooms.¹⁸⁴

Nevertheless, possible barriers to the implementation of coordinated care programs have been identified. According to Collins, Hewson, Munger et al., primary care providers have not yet developed the same relationship and communication with behavioral health providers, as they have with other specialty health providers.¹⁸⁵ This may be due to privacy laws implemented in the mental health field that protect against liability and limit a primary care physician's access to behavioral health information.¹⁸⁶ Therefore, efforts should be made to promote effective communication among primary care and behavioral health providers, in addition to expanding accessibility of mental health records to primary care providers in order for them to provide valuable behavioral health services to their patients.

In contrast to the less than three percent increase of psychiatrists between 2000 and 2009, the number of psychiatric mental health nurse practitioners has increased more than 40 percent from 2004 to 2010.¹⁸⁷ These trends may be attributed to each profession's expected income, given that psychiatric mental health nurse practitioners are expected to earn much more than colleagues in other specialties, versus psychiatrists who earn much less than their colleagues in general, or specialized practice.¹⁸⁸ Such recommendations have also prompted the debate centered on prescription privileges for psychologists.

Efforts to expand the scope of the psychology profession and its role on the prescription of psychotropic medication began in 1979 when a committee assigned by the American Psychological Association made recommendations to expand prescription authority.¹⁸⁹ During the 1980's such advocacy efforts became a state

¹⁸⁴ *Id.*

¹⁸⁵ Chris Collins, Denise Levis Hewson, Richard Munger & Torlen Wade, *Evolving Models of Behavioral Health Integration in Primary Care*, MILBANK MEMORIAL FUND 1, 15 (2010).

¹⁸⁶ *Id.*

¹⁸⁷ Pearlman, *supra* note 174, at 330.

¹⁸⁸ *Id.*

¹⁸⁹ Rachel P. Berland, *Introducing Patient Scope of Care: Psychologists*,

level issue, as states such as New Mexico and Louisiana have passed laws authorizing psychologists a limited right to prescribe.¹⁹⁰ However, this prescriptive authority is conditioned upon additional training and educational requirements.¹⁹¹ Furthermore, state legislative efforts have gained strength after coverage expansion of mental health and substance abuse services under the PPACA.

As aforementioned, increased access of mental health services in conjunction with emphasis on quality, access, and cost of healthcare through the PPACA, has precipitated influencing arguments by psychologists and psychiatrists influencing legislative decision-making. The American Society represents psychologists' interests for the Advancement of Pharmacotherapy, a division of the American Psychological Association. Psychologists' education and clinical training, demonstrated capability to safely prescribe psychotropic medications, and post-doctoral training requirements, are among the arguments presented in favor of psychologists' prescription rights.

Overall, encouragement of specialized education and training influences the expansion of the scope of services provided by mental health providers other than psychiatrists. This would represent an advantage in the provision of mental health services as they would not be limited by the availability of psychiatrists.

IX. Conclusions

Mental health care has been reviewed, in both a historical sense and in its current state. The overall conclusion behind this systemic review of mental health policy leads to the understanding that America has a crisis in mental health care. When psychiatric disorders choose their recipients they do not discriminate based on financial status, ethnicity, age, gender, or political perspectives. Instead, they complicate and cause disability, and rarely completely

Psychiatrists, and the Privilege to Prescribe Drugs, 6 ST. LOUIS U. J. OF HEALTH L. 425, 442-43 (2013).

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

remit without professional treatment. The history in mental health care has mimicked that of a rationing system, whereby patients were either completely denied treatment, or allocated insufficient mental health visits. Nonetheless, an adversarial relationship between insurance companies and providers has ensued. The PPACA has attempted to repair the broken system of attaining and maintaining mental health care in the U.S., with the aim to eventually achieve true parity. The disadvantages of the PPACA are inevitable, with limitations in provider availability, and variability on a state-by-state basis. The question of whether true parity will ever exist is yet to be determined; but strides have been made in this direction, evidenced by the landmark changes across presidential administrations from Presidents John F. Kennedy through Barack Obama.