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404 Provider Not Found: Contributions and Solutions to Inadequate Provider Networks for Behavioral Health Care

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404 PROVIDER NOT FOUND: CONTRIBUTIONS AND SOLUTIONS TO INADEQUATE PROVIDER NETWORKS FOR BEHAVIORAL HEALTH CARE

Travis C. Williams*

ABSTRACT

Despite the efforts of policymakers, access to in-network behavioral health care services has continued to lag relative to other types of health care. Many psychiatrists, for example, do not accept insurance, limiting access to their services to only those individuals who can afford to pay out of pocket. Several factors contribute to insurance networks’ paucity of behavioral health care providers, including low insurance reimbursement for behavioral health care services, inadequate regulation and enforcement, provider shortages, and a lack of access to telehealth services. To maximize the utility of existing regulatory structures, states should take an outcome-oriented enforcement approach that principally monitors appointment wait times to evaluate how well insurance networks meet their enrollees’ behavioral health needs. Additionally, policymakers should aim to strengthen internet infrastructure, broaden scopes of practice to encompass telehealth services, establish quantitative reimbursement minimums for some services, foster early interest in behavioral health careers, and adjust federal loan repayment programs to maximize recruitment to the behavioral health care workforce. Finally, lawmakers should create tax incentives to encourage behavioral health care providers to accept insurance.

* J.D. & M.P.H. Candidate, 2023, Georgia State University College of Law and School of Public Health. Thank you to Professors Erin C. Fuse Brown and Paul A. Lombardo, whose patience, guidance, and generosity were invaluable to the development of this Note. I would also like to thank the editors of the Georgia State University Law Review—past and present—which tenacity made this Note possible. Most of all, I would like to thank my family, whose love and support are the cornerstone of my life. In loving memory of Bryan D. Williams.
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INTRODUCTION

In the days before April 18, 2019, Kristi Bennett and her family called more than a dozen mental health facilities.1 Desperate to find help for her, they tried establishments both in and out of her home state of Kansas.2 According to her family, however, the facilities and Bennett’s insurance company, Blue Cross and Blue Shield of Kansas, blocked them at every turn.3 Before going to bed on April 18, Bennett took fifteen Wellbutrin.4 She never woke up.5

Kristi Bennett’s tragic story provides a bleak example of the human costs of a behavioral health care system that lacks the capacity to adequately care for people who need its help.6 Unfortunately, stories that illustrate the shortfalls of behavioral health treatment in the United States remain all too common.7 Many people suffering from a mental health crisis encounter a system generally ill-equipped to meet their needs.8

2. Id.
3. Id.
4. Id.
5. Id. Kristi Bennett’s family believes her overdose was accidental. Id. In response to her death, Blue Cross said, “Our hearts go out to the family and friends of Ms. Bennett, as they cope with their heartbreaking loss.” Id. Kansas state senators introduced a bipartisan bill, named after Bennett, limiting utilization reviews conducted by health plans on January 13, 2020. S.B. 249, 2020 Leg. Sess. (Kan. 2020); Kansas Senate Bill 249, LEGISCAN, https://legiscan.com/KS/bill/SB249/2019 [https://perma.cc/75R7-75Z9]. The bill died in committee on May 21, 2020. Id.
6. See Gutierrez & Shorman, supra note 1; see also, e.g., Lindsay Kalter, Treating Mental Illness in the ED, ASS’N OF AM. MED. COLLS. (Sept. 3, 2019), https://www.aamc.org/news-insights/treating-mental-illness-ed [https://perma.cc/3SRV-ZNFU] (describing the problems that mental health patients encounter in emergency departments). In this Note, the umbrella term “behavioral health” encompasses both mental health and substance use disorder (SUD).
7. See, e.g., Zachary Woerner, Note, The Failed Promise of Mental Health Parity in Virginia: A Missing Key in Mental Healthcare Access, 10 WM. & MARY BUS. L. REV. 549, 552 (2019). On November 18, 2013, Virginia State Senator Creigh Deeds’s son, Gus Deeds, was “prematurely released from an emergency custody order” after his father was unable to find him a hospital bed in the state of Virginia. Id. “Once released, Gus attacked his father and committed suicide.” Id.
The system’s failings have led politicians to call for a greater focus on behavioral health in recent years. The broader scale of behavioral health problems in the United States, which has been exacerbated by the COVID-19 pandemic since 2020, justifies these calls for greater awareness. In today’s troubling landscape of behavioral health care delivery, access to care continues to pose the most significant challenge.

Some of the trouble with access to behavioral health care stems from providers’ low participation in insurance networks compared with other types of care. Legislators have sought to counter this and other

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12. See generally STEPHEN P. MELEK, DANIEL PERLMAN & STODDARD DAVENTPORT, ADDICTION AND
insurance disparities with laws that mandate “parity” between the terms of coverage for behavioral health care and other types of care, such as medical and surgical benefits.\footnote{Daniel Polsky, \textit{Networks in ACA Marketplaces Are Narrower for Mental Health Care Than for Primary Care}, 36 \textit{Health Affairs}. 1624, 1625 (2017).} To that end, statutes and regulations passed at both the state and federal levels aim to remedy coverage disparities by targeting network adequacy for mental health and substance use disorder (SUD) services.\footnote{GA. CODE. ANN. § 33-24-29(c) (2019) (“Every insurer . . . shall be required to make available, either as part of or as an optional endorsement to all such policies providing major medical insurance coverage[,] . . . the treatment of mental disorders, which coverage shall be at least as extensive and provide at least the same degree of coverage . . . [as] for the treatment of other types of physical illnesses.”.)}

Thus, even though mental health parity laws have mandated that coverage for behavioral health care services be on par with other medical coverage, access to behavioral health care services continues to fall short of the promise of parity because of inadequate networks of participating behavioral health care providers. This Note discusses the complex framework of state and federal laws governing network adequacy and the market conditions that contribute to underrepresentation of behavioral health care providers in insurance networks. Part I provides a brief history of the legislation to date that affects access to mental health care, expanding on the significance of network adequacy by framing the problem within its broader social context.\textsuperscript{18} Part II analyzes the shortcomings of network adequacy regulations, the system of variable state-to-state enforcement of those regulations, and the provider shortages that complicate efforts to expand access.\textsuperscript{19} Finally, Part III proposes strengthening regulations and enforcement; expanding educational programs, “telehealth” services, and scopes of practice to address provider shortages; and incentivizing behavioral health care providers to join insurance networks.\textsuperscript{20}

\textbf{BACKGROUND}

The fight to ensure parity for coverage of behavioral health conditions has been incremental.\textsuperscript{21} Before encountering the problems presented by disparate coverage of behavioral health conditions, however, individuals must seek care in the first place, and social issues like the stigma surrounding behavioral health conditions and a lack of health insurance inhibit people from doing so.\textsuperscript{22} Social barriers and the

\textsuperscript{18} See infra Part I.
\textsuperscript{19} See infra Part II.
\textsuperscript{20} See infra Part III.
\textsuperscript{21} Taleed El-Sabawi, \textit{MHPAEA & Marble Cake: Parity & the Forgotten Frame of Federalism}, 124 DICK. L. REV. 591, 594 (2020) ("It took legislators decades to incrementally enact federal legislation . . . .").
\textsuperscript{22} E.g., Patrick W. Corrigan & Amy C. Watson, \textit{Understanding the Impact of Stigma on People with Mental Illness}, 1 WORLD PSYCHIATRY 16, 16–18 (2002); see also ROBIN A. COHEN, AMY E. CHA,
lag of legislation contribute to inadequate insurance networks, which negatively impact people seeking behavioral health care.²³

A. The Push for Parity: The Historical and Social Context of Legislative Efforts

Prior to the passage of the Mental Health Parity Act (MHPA) in 1996, many plans either lacked coverage for mental health services entirely or imposed significantly more restrictive limitations on those services than other types of health care.²⁴ The MHPA took the first steps to remedy these issues by requiring parity in annual and lifetime dollar limits for mental health benefits relative to medical or surgical benefits.²⁵ The legislation, however, left many other disparities intact and did not include provisions for SUD treatments.²⁶

Over a decade later, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded federal parity requirements to include “treatment limits, cost sharing, and in- and out-of-network coverage,” as well as broadening protections to include SUDs.²⁷ The MHPAEA also applied to a wider

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²³ Zhu et al., supra note 17 (noting that out-of-network care “jeopardizes access on the basis of affordability, provider quality, and availability”).

²⁴ AMANDA K. SARATA, CONG. RSLN. SERV., R41249, MENTAL HEALTH PARITY AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010, at 1 (2011), https://www.ncsl.org/documents/health/MHparity&mandates.pdf [https://perma.cc/SP8V-B4AB]; El-Sabawi, supra note 21, at 593. Limitations on mental health coverage included the decisions of insurers “to impose lower annual or lifetime dollar limits on mental health coverage; to limit treatment of mental health illnesses by covering fewer hospital days and outpatient office visits; and to increase cost sharing for mental health care services relative to medical or surgical services.” SARATA, supra.

²⁵ SARATA, supra note 24, at 2 (“[T]he [Mental Health Parity Act or] MHPA . . . requires parity in annual and aggregate lifetime limits . . .”).

²⁶ Valarie K. Blake, Seeking Insurance Parity During the Opioid Epidemic, 2019 UTAH L. REV. 811, 813 n.14 (2019) (“The [MHPA] was passed in 1996 to address the parity issues for mental health services. A similar law to address the challenges of parity in SUD would not follow for twelve years.”); GOODELL, supra note 13, at 2 (“[T]he [Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 or] MHPAEA also applied to the treatment of substance use disorders, which the MHPA did not address.”).

²⁷ GOODELL, supra note 13, at 2; 26 U.S.C. § 9812.
array of plans than the MHPA. Notably, however, neither the MHPA nor the MHPAEA actually mandate that plans provide behavioral health benefits; they simply require that plans that offer those benefits do so no more restrictively than they do for other types of care.

In 2010, The Patient Protection and Affordable Care Act (ACA), better known as the “Affordable Care Act” or “Obamacare,” applied the MHPAEA to the individual market and Marketplace plans that the ACA established. Perhaps more importantly, the ACA classified mental health and substance abuse treatment as one of its ten essential health benefits, which constituted an important step forward for the parity effort.

In addition to federal legislation, all states have now passed mental health parity statutes. Although this may suggest broad parity implementation at first glance, parity law is enforced by a “patchwork” of state and federal regulatory agencies, and enforcement has been minimal overall. This decentralized enforcement regime bears at least some responsibility for the disparities that persist, including those in the area of network adequacy. Individuals seeking behavioral health care, however, must overcome other barriers before they begin to feel the effects of coverage discrepancies and inadequate networks.

28. Goodell, supra note 13, at 2 ("The MHPAEA went beyond the MHPA and included Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and state Children’s Health Insurance Program (CHIP) plans.").
29. Id. at 1–2; Douglas et al., supra note 13.
31. 42 U.S.C. § 18022(b)(1)(E); see also Goodell, supra note 13, at 2 (noting that, as a result of classifying mental health benefits as an essential health benefit, the Patient Protection and Affordable Care Act (ACA) “went beyond the MHPAEA by mandating coverage instead of requiring parity only if coverage is provided”).
32. Thomson Reuters, Mental Health and Substance Abuse Parity and Coverage Requirements, 0100 SURVEYS 41 (2019). Additionally, mental health parity statutes have been passed in the District of Columbia, Guam, and Puerto Rico. Id.
34. El-Sabawi, supra note 21, at 595; Goodell, supra note 13, at 4; Melek et al., supra note 12, at 4 (depicting high rates of out-of-network utilization for behavioral health care services throughout the United States).
35. See generally Patrick W. Corrigan, Benjamin G. Druss & Deborah A. Perlick, The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care, 15 PSYCH. SCI. PUB. INT. 37 (2014) (exploring the negative impact of stigma on mental health care participation).
Stigma surrounding mental health conditions presents perhaps the most substantial pre-access barrier to behavioral health care. Negative public attitudes toward mental health conditions may adversely impact individuals’ ability to obtain treatment and employment, which in turn harms their potential to function as fully accepted members of society. Moreover, people who suffer from mental health conditions may internalize those public attitudes, which can result in “self-stigma” by engendering low self-esteem or feelings of indifference about their own conditions. In turn, these negative inward attitudes may discourage people from seeking much-needed care, and many people with serious mental health conditions ultimately do not obtain treatment. Low rates of utilization in behavioral health care are especially troubling considering that medical studies have consistently demonstrated the effectiveness of treatment.

Stigma, however, presents only the first hurdle. Despite the ACA’s reforms, many Americans remain without health insurance. For most of those Americans, the cost of receiving mental health treatment, or any other kind of treatment for that matter, is prohibitive.

36. See Corrigan & Watson, supra note 22.
37. Id. at 17 (linking public stigma to a lack of help for those with mental illness, “social avoidance” of mentally ill members of society, and a “detrimental impact on obtaining good jobs”).
38. Id. at 17–18. Although self-stigma in some cases may energize mental health patients by causing them to become “righteously angry because of the prejudice that they have experienced,” thereby leading them to “becom[e] more active participants in their treatment plan,” in many other cases, it may have a suppressing effect. Id. at 18.
39. Corrigan et al., supra note 35, at 40, 44, 47.
40. Blake, supra note 26, at 813.
41. See HONIBERG ET AL., supra note 11, at 1.
42. COHEN ET AL., supra note 22 (“In the second half of 2019, 35.7 million persons of all ages (11.0%) were uninsured—significantly higher than the first 6 months of 2019 (30.7 million, 9.5%).”). Though the precise toll that COVID-19 has taken on the number of insured Americans is currently unclear, high unemployment rates and information from the federal Health Insurance Marketplace support the conclusion that more Americans have lost health insurance because of the pandemic. BUREAU OF LAB. STAT., USDL-20-1650, THE EMPLOYMENT SITUATION—AUGUST 2020, at 1 (2020), https://www.bls.gov/news.release/archives/empsit_09042020.pdf [https://perma.cc/B7BJ-8CVW] (indicating that the August 2020 unemployment rate of 8.4%, though falling, is over twice the rate from August 2019); Marketplace Coverage & Coronavirus, HEALTHCARE.GOV, https://www.healthcare.gov/coronavirus/ [https://perma.cc/NYS4-P9ZA].
individuals with mental health concerns lack insurance more commonly than other patients. Even for those who do have health insurance, many individuals face hindrances to receiving mental health treatment, such as coverage denials, high out-of-pocket costs, and problems finding behavioral health care providers within their plan’s network. Mental health patients encounter these obstacles at higher rates compared to patients seeking other care. And even with insurance, patients with mental health conditions frequently seem to have trouble locating in-network providers within reasonable distances and without long wait times for an appointment.

B. A Backdrop of “Narrow Networks”

At least some of the trouble with locating in-network health care providers is by design; insurers use “narrow networks” as a method of containing costs. Although the ACA closed the door to many measures that insurers had used to keep costs down, it left the door open for insurers to craft increasingly narrow networks. Consumers

44. Kathleen Rowan, Donna D. McAlpine & Lynn A. Blewett, Access and Cost Barriers to Mental Health Care, By Insurance Status, 1999–2010, 32 HEALTH AFFS. 1723, 1723 (2013) (“People with mental illness are less likely to have health insurance than those without mental health problems. . . . Rachel Garfield and colleagues found that [thirty-seven] percent of working-age adults with severe mental illnesses were uninsured for at least part of the year, compared to [twenty-eight] percent of people without severe mental illness.”).

45. HONBERG ET AL., supra note 11, at 1–2.

46. GODDELL, supra note 13, at 4.

47. See John V. Jacobi & Tara Adams Ragone, Seton Hall L. CTR. FOR HEALTH & PHARM. L. & POL’Y, ACCESS TO BEHAVIORAL HEALTH SERVICES IN MARKETPLACE PLANS IN NEW JERSEY: THE PUZZLE OF PARITY 16 (2016), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2814596 [https://perma.cc/R6B5-YFFN] (noting that inadequacy of behavioral health care provider networks for plans offered by the federal Marketplace was a “prominent theme” in conversations with providers and advocates); see also HONBERG ET AL., supra note 11, at 2 (describing a survey that found that a “significant percentage of respondents” reported difficulty finding in-network behavioral health care providers).

48. Zhu et al., supra note 17, at 1624 (describing insurers’ increased use of “narrow networks” as a cost-cutting measure).

49. See id. (describing various cost-cutting practices that were prohibited with the passage of the ACA, including “standardization of benefits, limits on maximum out-of-pocket spending, and community rating”).
now frequently encounter narrow network options on the individual market and through employer-based coverage.50

Narrow networks enable insurers to cut costs in part by excluding high-cost providers.51 Providers participating in these networks agree to accept lower prices for their services in exchange for the expectation of greater patient volume.52 Though cost-cutting measures typically go hand-in-hand with maximizing profits, tailored networks also allow insurers to offer lower premiums, which “remain the most important factor in plan choice for consumers.”53 With fewer ways for insurance providers to economize after the ACA, entirely eliminating the use of narrow networks would curtail insurers’ ability to deliver lower premiums.54

Nonetheless, the savings from narrow networks can come at the price of adversely affecting access to health care.55 Consumers who choose a plan with a narrow network implicitly accept the trade-off of a more restricted choice of health care providers.56 Although narrow networks can negatively impact access to all types of care, they pose a particularly acute problem for behavioral health care.57 Due to the

50. Tracy Anderman, What to Know About Narrow Network Health Insurance Plans, CONSUMER REPS. (Nov. 23, 2018), https://www.consumerreports.org/health-insurance/what-to-know-about-narrow-network-health-insurance-plans/ (indicating that one in five plans sold on ACA health exchanges and one third of Medicare Advantage plans have narrow networks, and 18% of companies with five thousand employees “offer at least one narrow network plan”).
51. Zhu et al., supra note 17, at 1624.
52. Anderman, supra note 50.
54. Zhu et al., supra note 17, at 1624.
55. Id. at 1625.
56. Robert Pear, Lower Health Insurance Premiums to Come at Cost of Fewer Choices, N.Y. TIMES (Sept. 22, 2013), https://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html (indicating that many consumers, however, appear to be satisfied with the trade-off between price and access. GOV’T ACCOUNTABILITY OFF., GAO-16-761, PATIENT PROTECTION AND AFFORDABLE CARE ACT: MOST ENROLLEES REPORTED SATISFACTION WITH THEIR HEALTH PLANS, ALTHOUGH SOME CONCERNS EXIST 20–21 (2016) (“While stakeholders have expressed concerns with [narrow network] plans, consumers continue to enroll in them and indicate they are willing to choose a plan with a narrow network to reduce their premiums.”).
57. Pear, supra note 56; SARATA, supra note 24 (“[I]n- and out-of-network coverage has often been
potentially high expense of mental health treatment, some plans may intentionally seek to exclude mental health providers.\textsuperscript{58}

\textit{C. The Problem of Network Inadequacy}

Despite attempts to specifically ensure adequate networks of behavioral health care providers, network size continues to fall short of legislators’ aspirations.\textsuperscript{59} In the United States between 2013 and 2015, the rate of out-of-network utilization for inpatient behavioral care services was roughly three to four times higher than the rate for medical and surgical benefits.\textsuperscript{60} For outpatient services, the same proportion was about three to six times more.\textsuperscript{61} In 2015, every state but Nebraska saw disproportionate out-of-network utilization for behavioral office visits.\textsuperscript{62}

Moreover, the across-the-board disparities in out-of-network utilization seem to grow each year.\textsuperscript{63} Out-of-network utilization does not necessarily indicate network inadequacy because patients may choose to go out of network, but the dwindling behavioral health workforce and the scale of out-of-network utilization for behavioral health care services suggest that a lack of patient choice—not an\textsuperscript{58} variable between mental health and medical and surgical services.”); Valarie Blake, Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform, 16 MINN. J. L. SCI. & TECH. 63, 95 (2015) (noting that mental health providers “have historically raised network adequacy concerns”); GoodeLL, supra note 13, at 5 (detailing various state studies that found low psychiatrist participation in networks); Zhu et al., supra note 17.

\textsuperscript{59} MARK A. HALL & PAUL B. GINSBURG, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POL’Y, A BETTER APPROACH TO REGULATING PROVIDER NETWORK ADEQUACY 3 (2017), https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf [https://perma.cc/Y2ZW-BCV8] (“[H]ealth plans might purposefully understaff certain specialties in order to avoid attracting people with expensive existing conditions, such as cancer or mental illness.”).

\textsuperscript{60} MELEK ET AL., supra note 12, at 1.

\textsuperscript{61} Id.

\textsuperscript{62} Id. at 4, 4 fig.4.

\textsuperscript{63} See id. at 6 fig.6.
abundance of it—drives the disproportionality. Despite the ACA and all states’ promulgation of network adequacy requirements, these market trends reflect a reality increasingly at odds with legislators’ aims.

Inadequate behavioral health care networks create three primary barriers to care: longer wait times, farther distances, and higher costs. Long wait times do not simply inconvenience patients; each day that would-be patients are made to wait brings with it a higher likelihood that they will ultimately not receive the care they need. According to a 2015 study of psychiatrists’ waiting periods in three cities, prospective patients faced an average wait time of twenty-five days 

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64. Id. at 1, 2; John M. Grohol, Mental Health Professionals: US Statistics 2017, PSYCHCENTRAL (Apr. 9, 2019), https://psychcentral.com/blog/mental-health-professionals-us-statistics-2017/ [https://perma.cc/5LU3-Q7KU] (“Psychiatry has suffered a devastating 36% decrease in its ranks since 2011.”); Mental Health Care Health Professional Shortage Areas (HPSAs), KAISER FAM. FOUND. [hereinafter Mental Health Professional Shortage Areas Table], https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas [https://perma.cc/5WEK-53VU] (Sept. 30, 2021) (documenting the widespread shortages of mental health providers in the United States and all of its territories); see also Susan H. Busch & Kelly A. Kyanko, Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills, 39 HEALTH AFFS. 975, 980–81 (2020) (“Interestingly, even among participants [of a study] who did not report any [provider directory] inaccuracies, one in five used an out-of-network mental health provider. This suggests that there are multiple reasons for high out-of-network use in mental health, including the desire to maintain continuity with a provider who is no longer in network or the belief that an out-of-network provider is of higher quality.”).

65. See supra note 59 and accompanying text; see also DOUGLAS ET AL., supra note 13, at 4, 13; John V. Jacobi, Tara Adams Ragone & Kate Greenwood, Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform, 120 PENN ST. L. REV. 109, 140 (2015) (noting that the ACA created the first federal network adequacy regulations for individual and small group plans and discussing pre-ACA, state-level network adequacy regulations for health maintenance organizations (HMOs) and preferred provider organizations (PPOs)). See generally Thomson Reuters, supra note 32 (listing parity statutes in all fifty states).

66. JACOBI & RAGONE, supra note 47, at 72, 18 (describing reports of patients’ long wait times and travel distances); Zhu et al., supra note 17 (noting that out-of-network care “jeopardiz[es] access on the basis of affordability, provider quality, and availability”);

67. Cindy Dampier, Mental Health Care Appointments Often Come with a Long Wait. 3 Ways to Cope While Help Is Delayed, CHI. TRIB. (Oct. 25, 2018, 4:35 PM), https://www.chicagotribune.com/lifestyles/sc-fam-mental-health-wait-times-1030-story.html [https://perma.cc/47EM-AQTR] (“[W]ait times have a very real impact. ‘For every one day of wait time,’ says National Council for Behavioral Health President and CEO Linda Rosenberg, ‘you lose [one] percent of the patients—so if you have a [twenty-one]-day wait, [twenty-one] percent of the patients seeking care just will give up and not show up.’”).
until the first available appointment. Adolescents may wait twice as long.

Further, inadequate networks often mean that individuals seeking behavioral care must travel greater distances to reach an in-network provider. The problem compounds in rural areas, where patients often struggle to find behavioral health care providers close to them because health care facilities tend to be located in more densely populated areas. Uneven distributions persist despite federal attempts to ensure a more even apportionment of providers. Even in nonrural areas, providers may not be able to meet their communities’ immediate behavioral needs. As a result, desperate patients may have no choice but to travel to faraway places for care.

Additionally, inadequate networks entail higher costs for consumers: insurers contract to pay in-network providers lower prices, and when a patient receives out-of-network care, insurers usually pass on at least a portion of the higher price. In many situations, patients

70. JACOBI & RAGONE, supra note 47, at 16 (“We generally heard concerns that plan networks contained an inadequate number of appropriate [behavioral health care] providers, which meant that patients had to wait extended periods of time or travel long distances for appointments—or simply went without care. . . We also heard concerns that in-network provider offices did not have flexible hours for patients who work or were not accessible by public transportation.”).
71. See JOANNE M. CHEDI, U.S. DEP’T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., OEI-02-17-00490, PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO’S MEDICAID MANAGED CARE 6, 7 (2019).
72. See 45 C.F.R. § 156.235(a)(1) (2017) (“A QHP issuer that uses a provider network must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP’s service area, in accordance with the Exchange’s network adequacy standards.”).
73. Kalter, supra note 6 (telling the story of one patient struggling with suicidal thoughts whose parents drove her eleven hours from Michigan to the University of North Carolina to see a psychiatrist).
may unwittingly receive care from an out-of-network provider. Until recently, providers and insurers could freely subject many of these patients to surprise medical bills. Although the patients were unaware that they were receiving care from an out-of-network provider, insurers could still impose greater cost-sharing requirements, and out-of-network providers could bill a patient for the difference between the price of their services and the amount that the patient’s insurance company would pay. Blame for these bills often fell on providers and insurers—not patients—because patients based their decisions to see a provider on insurers’ erroneous provider directories.

Congress banned most of these billing practices with the No Surprises Act, which passed at the end of 2020 and became effective on January 1, 2022. Before the passage of the No Surprises Act, only


77. Mangan, supra note 74 (“Customers who seek care outside of the plan’s network of providers typically have to personally pay more for the care, because the plan either does not cover the services at all, or it covers a much smaller share of the cost.”). Providers’ practice of billing patients for this balance is known as “balance billing.”

78. Busch & Kyanko, supra note 64, at 975 (“Patients use [provider] directories to locate an in-network provider or to determine whether a specific provider is in the plan’s network. Patients’ use of inaccurate information in directories may result in . . . mistaken use of an out-of-network provider (that is, the receipt of a ‘surprise bill’) . . . ”).

a few states had adopted comprehensive legislation to address surprise billing.\textsuperscript{80} The relief from Congress came too late for many patients: one in five insured adults received a surprise medical bill between 2018 and 2020.\textsuperscript{81} Although the No Surprises Act undoubtedly provides consolation for many behavioral health patients, the degree to which it will alter total out-of-network behavioral health care spending remains unclear due to uncertainty about the extent to which patients knowingly seek out-of-network care.\textsuperscript{82}

Consumers are not the only ones who bear the stress of inadequate systems of behavioral health care delivery. Systemic failures translate to a higher burden on the criminal justice system and emergency departments (EDs), neither of which are well suited to assist behavioral health patients.\textsuperscript{83} Many EDs seek to divert mental health patients as

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\textsuperscript{81} Pollitz et al., \textit{supra} note 80.

\textsuperscript{82} See Gary Claxton, Matthew Rae, Cynthia Cox & Larry Levitt, \textit{An Analysis of Out-of-Network Claims in Large Employer Health Plans}, PETERSON-KFF HEALTH SYS. TRACKER (Aug. 13, 2018), https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start [https://perma.cc/F3QZ-PJHQ] (showing that enrollees using outpatient mental health services are significantly more likely to have a claim from an out-of-network provider); \textit{see also} Busch & Kyanko, \textit{supra} note 64 (suggesting that mental health patients may have multiple reasons to knowingly seek care from an out-of-network provider, including a desire to continue treatment with a formerly in-network provider or a belief that an out-of-network provider furnishes higher quality care).

quickly as possible. Yet, in unwitting defiance of the limited abilities of EDs, behavioral health patients increasingly turn up for help. One in eight ED visits relates to mental health or substance use issues. Large volumes of behavioral patients also impact EDs’ capacities to care for other patients with life-threatening physical conditions. Expanding access to behavioral health care outside of EDs would reduce their share of the burden. To address inadequate networks, their constituent causes and the landscape of legislative responses designed to address them require examination.

II. ANALYSIS

Effective regulation of network adequacy requires a delicate balancing act; several market behaviors and conditions contribute to network inadequacy. Five categories of tools used to regulate

system; former U.S. Representative Beto O’Rourke said, “[W]hen [you are] talking about access to health care, [Texas is] the least insured state in the country; [the] number one provider of mental health care is the county jail system; [the] largest inpatient mental health care facility is the Harris County jail . . . .”).

84. Zeller, supra note 8, at 3 (“Unfortunately, many systems have sought to divert psychiatric patients from the ED as if they do not belong there.”); Judy Schwartz Haley, Mental Health Emergency: What to Expect in the ER, DIGNITY HEALTH (July 22, 2017), https://www.dignityhealth.org/articles/mental-health-emergency-what-to-expect-in-the-er [https://perma.cc/5HC8-FJLC] (“In some cases, [mental health patients] may be released from the ER and told to follow up with a mental health professional.”); see also, e.g., Jane Flasch, Law May Have Forced Hospital to Release Daniel Prude Hours Before Fatal RPD Encounter, WHAM-TV (Sept. 8, 2020), https://13wham.com/news/local/law-may-have-forced-hospital-to-release-daniel-prude-hours-before-fatal-rpd-encounter [https://perma.cc/9HEH-CUY3] (reporting that, out of the 7,000 mental hygiene transports that had occurred in Monroe County, New York, in 2020 by September, only “about one of every four patients [was] ever admitted”). But see AUDREY J. WEISS, MARGUERITE L. BARRETT, KEVIN C. HESLIN & CAROL STOCKS, TRENDS IN EMERGENCY DEPARTMENT VISITS INVOLVING MENTAL AND SUBSTANCE USE DISORDERS, 2006–2013, at 1 (2016), https://www.hcup-us.ahrq.gov/reports/statbriefs/sb216-Mental-Substance-Use-Disorder-ED-Visit-Trends.pdf [https://perma.cc/T6ZB-M36E]; Zeller, supra note 8. Compared to all other types of ED visits, mental and substance use disorder ED visits are more than twice as likely to result in hospital admissions. WEISS ET AL., supra; Zeller, supra note 8. These admissions put a strain on hospitals’ already limited number of inpatient beds. See Zeller, supra note 8, at 3.

85. Kalter, supra note 6 (“ED visits related to mental health and substance-use issues increased more than 44% between 2006 and 2014 . . . with suicidal ideation visits growing by nearly 415%.”).

86. Id.; Zeller, supra note 8, at 3.

87. Zeller, supra note 8, at 3.

88. See Kalter, supra note 6 (“Given the lack of capacity in mental health care delivery systems, a substantial volume continues to fall on emergency departments as the de facto primary care.” [Robert Trestman, MD, PhD, Chair of Psychiatry at the Virginia Tech Carilion School of Medicine] notes.”).

89. See HALL & GINSBURG, supra note 58, at 6 (“Current lawmakers are understandably cautious
network adequacy have, to date, fallen short of their aspirations in the behavioral health specialties: (1) qualitative standards, (2) quantitative standards, (3) “any willing provider” laws (AWP), (4) parity enforcement in behavioral health reimbursement rates, and (5) provider directory requirements. On the supply side, severe shortages of behavioral health care providers inhibit the efficacy of network adequacy regulations. Efforts to bridge the supply-demand gap, namely financial assistance programs for medical students and bids to expand telehealth services, have seen limited success so far.

A. The Inadequacies of Network Adequacy Regulations

To mitigate the risks that narrow insurance networks present to consumers, all states and the Department of Health and Human Services (HHS)—pursuant to ACA—promulgate regulations targeting network adequacy. Ultimately, network adequacy standards aim to ensure access to care. These standards fall into two categories: qualitative and quantitative. On the one hand, qualitative approaches supply broad, ambiguous standards, such as requiring plans to include enough providers to make services available to enrollees “without unreasonable delay.” On the other hand, quantitative standards establish specific thresholds for network capacity, provider distribution, and appointment wait times that insurance networks must meet.

HHS opted for the qualitative approach for Marketplace plans, creating a “baseline” that leaves room for states to regulate according
to their needs. Many states simply extend HHS’s ambiguity, which does little on its own to move the needle on network adequacy. Other states have tried to shore up the ACA’s slack by taking the quantitative approach, but the ability of quantitative standards to buttress network adequacy has also been limited. Due to these limitations, most states that employ quantitative standards also use qualitative ones. Inadequate enforcement of both types of standards, however, contributes to their fecklessness to date. Although many states require insurers to cover out-of-network care at in-network rates when enrollees do not have timely access to in-network services, patients and their providers typically must show that the care sought is both unavailable in network and medically necessary—a difficult task for behavioral health care services. Moreover, out-of-network behavioral health care providers may still bill a privately insured patient who chooses to go out of network for the balance between the

98. § 156.230(a)(2) (providing that provider networks on the federal Marketplace must be able to supply mental health and substance use disorder services “without unreasonable delay” but giving no guidance as to what constitutes “unreasonable delay”); Jacobi et al., supra note 65, at 142 (“Neither the federal statute nor regulations define key terms, like ‘unreasonable delay,’ instead ‘leaving the implementation of specific standards either to insurers or to the states.’”); Blake, supra note 57, at 69 (“The federal government creates a baseline upon which the states can build more stringent and locally relevant guidelines that reflect their unique health care markets and level of competition.”).

99. Jacobi et al., supra note 65 (discussing “broad” and “subjective” state standards for network adequacy, such as “reasonable access to providers”).

100. See infra Part II.A.2.

101. HALL & Ginsburg, supra note 58, at 8 (“A quantitative approach, however, faces a number of difficulties, on account of which most states with quantitative metrics still also employ qualitative standards.”).


103. HALL & Ginsburg, supra note 58, at 13 (“One obvious remedy for patients who do not have timely access to services they need is to require insurers to pay or reimburse the cost of seeking care out of network. This is required by the [National Alliance of Insurance Commissioner (NAIC)]’s Model Act, and by many (but not all) states.” (citations omitted)); e.g., CAL. CODE REGS. tit. 28, § 1300.67.2.(c)(7)(B) (2019) (“Plans shall arrange for the provision of specialty services from specialists outside the plan’s contracted network if unavailable within the network, when medically necessary for the enrollee’s condition.”). See generally Darcy Lockman, Is My Work “Medically Necessary”? How Insurance Companies Try to Get Around Rules for Mental Health Care, Slate (Jan. 12, 2015, 8:35 AM), https://slate.com/technology/2015/01/medically-necessary-psychotherapy-insurance-companies-try-to-evade-mental-health-parity-rules.html [https://perma.cc/TCU5-9F6A] (describing one psychiatrist’s difficulties with denials of coverage for her patients’ psychotherapy because of medical necessity).
price of the services rendered and the amount the patient’s insurer agrees to pay.\textsuperscript{104}

1. \textit{Qualitative Standards}

Qualitative standards often come hand-in-hand with relatively lax methods for measuring compliance. Most commonly, state regulators simply require that insurers articulate a plan for determining the adequacy of their networks.\textsuperscript{105} These regulators often do not conduct routine audits, relying mostly on consumer complaints to monitor the sufficiency of networks.\textsuperscript{106} But the extent to which consumers file these complaints, as well as the complaints’ cogency, appears uncertain: unless patients or providers seek prior authorization from an insurer to go out of network, no “decision point” for review exists.\textsuperscript{107} Ultimately, these methods mostly leave it to insurers to police their own compliance.\textsuperscript{108} Although some states take a more proactive enforcement approach, the widespread combination of toothless standards and toothless enforcement has no doubt contributed to inadequate representation of behavioral health specialists in insurance networks.\textsuperscript{109}

\textsuperscript{104} HALL \& GINSBURG, \textit{supra} note 58, at 20 n.69 ("Regulation of network adequacy under Medicare and Medicaid avoids [the] problem [of providers using strict adequacy rules to force insurers to agree to inflated prices] because providers are not permitted to freely ‘balance bill’ those beneficiaries. But, under private insurance, providers can charge ‘whatever the market will bear.’").

\textsuperscript{105} \textit{Id.} at 7.

\textsuperscript{106} \textit{Id.}

\textsuperscript{107} See \textit{id.} at 15 ("One difficulty in making external review routinely available for network inadequacy is needing a clear triggering event to seek review. . . . For network access, the need arises simply from a patient’s inability to secure an adequate, timely appointment or referral. Unless a patient or provider seeks, and is denied, prior authorization, there is no crystallized decision point.").

\textsuperscript{108} \textit{Id.} at 7 ("Once regulators approve an insurer’s network adequacy plan, typically they then leave it to insurers to self-monitor their own compliance.").

\textsuperscript{109} See \textit{id.} ("This more passive or reactive regulatory approach is not at all universal; many states are more prescriptive and proactive. However, self-certification under a general qualitative standard is the approach still used by almost half the states in the private insurance market.").
2. Quantitative Standards

In addition to proactive network adequacy enforcement, states may also lay out their requirements more clearly. The quantitative standards that some states employ can be divided primarily into three categories: (a) geographic criteria, (b) appointment wait-time requirements, and (c) provider-to-enrollee ratios.

a. Geographic Criteria

Of the three primary quantitative standards, states use geographic criteria most widely. The geographic criteria typically establish that network providers must be located within a prescribed number of miles from a percentage of the enrollees’ residences or the plan’s geographic boundaries, or that carriers must meet the National Committee for Quality Assurance’s geographic standards. Geographic requirements vary widely from state to state. Some states establish different standards for different plan types and for urban and rural areas, though differences in population and demand for services often justify different standards. Of the twenty-six states that had

110. See LEGAL ACTION CTR., SPOTLIGHT ON NETWORK ADEQUACY STANDARDS FOR SUBSTANCE USE DISORDER AND MENTAL HEALTH SERVICES 15 (2020) https://www.lac.org/assets/files/Network-Adequacy-Spotlight-final-UTO.pdf [https://perma.cc/6HYJ-U5N7] ("Quantitative metrics create greater accountability and uniformity across health plans and reduce the ability of plans to define and monitor their own performance under a qualitative standard.").


112. LEGAL ACTION CTR., supra note 110, at 1; DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111 (showing that, out of twenty-three states that employed quantitative network requirements in August 2016, twenty-one of them used geographic standards, twelve adopted wait-time requirements, and nine adopted provider-to-enrollee ratios).

113. DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111, at 3–27.

114. See id. at 3–24.

115. Id. at 5–6, 13–14, 21–22 (showing Texas’s differing standards for HMOs and PPOs and listing Colorado and Nevada’s geographic requirements). In Colorado, geographic requirements for some types of providers range from five miles in the most densely populated metro areas to one hundred miles or more in the most remote areas. Id. at 5–6. In Nevada, limits are expressed in terms of maximum travel times and range from ten minutes in the most densely populated areas to 145 minutes in the most remote areas. Id. at 13–14.
established geographic criteria as of May 2020, fewer than half used standards that applied specifically to mental health and SUD treatment.\footnote{116. LEGAL ACTION CTR., supra note 110, at 8 (listing twelve states which have adopted precise geographic standards that specifically apply the treatment of mental health disorders and SUDs: California, Colorado, Delaware, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, Oregon, Pennsylvania, and Vermont).} In theory, the utility of geographic criteria lies in their capacity to combat disparate concentrations of behavioral health care providers.\footnote{117. See, e.g., CHIEDI, supra note 71, at 7–8, 8 exhibit 2.} Geo-mapping programs have made implementation and compliance determinations easier in recent years, which may explain their prevalence relative to other quantitative standards.\footnote{118. HALL & GINSBURG, supra note 58, at 9 (“Geo-mapping programs now make it feasible to determine how close (either by time or distance) subscribers are to providers . . . ”).} In practice, however, the states that present the direst need for services and the greatest challenges to access often use accommodating standards, which may simply reflect the inherent tension between those states’ desire to expand access and their implicit acknowledgment that they lack the providers to do so.\footnote{119. Compare Suicide Mortality by State, CTRS. FOR DISEASE CONTROL & PREVENTION, NAT’L CTR. FOR HEALTH STAT., https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm [https://perma.cc/MM89-SXP3] (Feb. 11, 2021) (showing New Mexico as the state with the second-highest rate of suicide by population), and CHIEDI, supra note 71, at 7–8, 8 exhibit 2 (detailing irregular distribution of behavioral health care providers in New Mexico), with N.M. CODE R. § 13.10.22(A)(4) (LexisNexis 2019) (outlining practices that health care plans should employ to ensure “reasonable and reliable access,” including to “attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each covered person, and the type of specialty care needed” (emphasis added)).} 

\textit{b. Appointment Wait-Time Requirements} 

The second most common standards that states impose are appointment wait-time requirements.\footnote{120. LEGAL ACTION CTR., supra note 110, at 8–9 (indicating that, as of May 2020, twenty-six states have adopted geographic standards, seventeen states have adopted appointment wait-time standards, and thirteen states have adopted provider-to-enrollee ratios); DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111, at 1–2 (showing that, out of twenty-three states that employed quantitative network requirements in August 2016, twenty-one adopted geographic standards, twelve adopted wait-time requirements, and nine adopted provider-to-enrollee ratios).} These regulations aim to ensure that any enrollee in a plan that falls under the purview of the
regulation can receive timely access to care.121 Like geographic requirements, maximum appointment wait times can vary widely depending on the state and type of care.122 These requirements may also include mandating hours of operation for certain types of care.123

Some studies provide good reason to doubt insurers’ compliance with appointment wait-time requirements, particularly for behavioral health conditions.124 In Texas, for example, a state regulation last amended in 2013 requires preferred provider organizations (PPOs) to “ensure that routine care is available and accessible from preferred providers . . . within two weeks for behavioral health conditions . . . “125 Nonetheless, a 2015 study of psychiatrist appointment wait times in Houston (along with two other cities outside of Texas), whose findings encompassed PPOs, reflected average wait times of twenty-five days—more than twice the length of time required by the regulation.126 Comparisons of states that use appointment wait-time requirements with states that do not, however, may better illuminate the impact of these standards; for instance, wait times for psychiatrist appointments in Ohio, which does not employ appointment wait-time standards, can be nearly twice as long as in Houston.127

121. Busch & Kyanko, supra note 64, at 981 (describing these requirements as “timely access standards”).
122. See DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111, at 3–24.
123. Nat’l Ass’n of Ins. Comm’rs, Health Benefit Plan Network Access and Adequacy Model Act § 5(B)(6) (2015); DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111, at 11, 13, 20 (showing Mississippi, Nebraska, and North Dakota as three states that impose hours-of-operation requirements as their only quantitative standard).
124. Compare, e.g., Malowney et al., supra note 68 (finding twenty-five-day average wait times to see a psychiatrist in Houston for simulated patients with preferred provider organization (PPO) coverage), with 28 TEX. ADMIN. CODE § 3.3704(f)(10)(B) (2013) (requiring PPOs to “ensure that routine care is available and accessible from preferred providers . . . within two weeks for behavioral health conditions”).
125. § 3.3704(f)(10)(B).
126. Malowney et al., supra note 68. The study’s methods involved calling psychiatrists in three cities and posing as “patient[s] claiming to have one of three coverage types: [Blue Cross Blue Shield (BCBS)] PPO, Medicare, or self-pay.” Id. at 94. Although the study’s authors “were able to obtain appointments more frequently by using BCBS or self-pay compared with Medicare, this difference was not significant.” Id. at 95. The study did show, however, that Houston psychiatrists were more likely than psychiatrists from the other two cities to answer calls and book appointments, though Houston psychiatrists were less likely to return calls. Id.
127. LEGAL ACTION CTR., supra note 110, at 8 (presenting a list of all states that use appointment
c. Provider-to-Enrollee Ratios or Minimum Number of Providers

Provider-to-enrollee ratios or minimum number of providers requirements comprise the most seldomly enacted quantitative standards group. Populous states seemingly tend to use these standards more frequently than their more sparsely populated counterparts. Despite relatively infrequent imposition of these standards, the prominence of provider-to-enrollee ratios in the National Alliance of Insurance Commissioner’s (NAIC) Health Benefit Plan Network Access and Adequacy Model Act (Model Act) suggests that they are an important measure of a plan’s ability to meet the needs of its members. As of December 2019, however, only three states had adopted NAIC’s Model Act, and only thirteen states had promulgated provider-to-enrollee or minimum-number-of-providers standards as of May 2020. Of those thirteen states, only five had requirements that applied specifically to behavioral health care providers.

Much like the other two quantitative network adequacy standards, minimum ratios do not appear to be single-handedly effective in wait-time standards, which does not include Ohio). Compare Malowney et al., supra note 68 (demonstrating average wait times of twenty-five days), with Steinman et al., supra note 69, at 782 (“The median wait time [for an adolescent seeking a psychiatry appointment in Ohio] was 50 days . . . ”).

128. LEGAL ACTION CTR., supra note 110, at 8–9 (indicating that, as of May 2020, twenty-six states have adopted geographic standards, seventeen have adopted appointment wait-time standards, and thirteen have adopted provider-to-enrollee ratios); DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111 (showing that, out of twenty-three states that employed quantitative network requirements in August 2016, twenty-one used geographic standards, twelve adopted wait-time requirements, and nine adopted provider-to-enrollee ratios).

129. Compare DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111, at 2 (listing California, New Jersey, and New York as three of the nine states using provider-to-enrollee ratios), with States—Ranked by Size and Population, INTERNET PUB. LIB., https://www.ipl.org/div/stateknow/popchart.html [https://perma.cc/T3Z3-35A8] (ranking California as the most populous state, New York as the third most populous, and New Jersey as the eleventh most populous according to 2010 Census Bureau data).


expanding access to affordable behavioral health care. The five states that use behavioral-health-specific ratios have among the highest percentages of out-of-network utilization for behavioral health care services. A recent uptick in the number of states that apply these standards, however, may signal that state regulators increasingly see access-expanding potential in provider-to-enrollee ratios.

d. Lingering Flaws in Quantitative Standards and Their Enforcement

Overall, no single quantitative standard or combination of standards seems to serve as the holy grail of network regulation. If a state does not have enough providers to meet the need for behavioral health care, imposing quantitative standards will simply ensure networks’ noncompliance. Perhaps this certain failure explains why many states do not use quantitative standards. Among states that do, little consensus exists about how to quantify “reasonable access to care.”

134. MELEK ET AL., supra note 12, at 4 fig.4 (indicating high rates of out-of-network utilization in Colorado, Delaware, Illinois, Maine, and New York); LEGAL ACTION CTR., supra note 110, at 9.
135. Compare LEGAL ACTION CTR., supra note 110, at 9 (listing five states that, as of May 2020, have adopted provider-to-enrollee ratios or minimum-number-of-provider requirements for mental health and SUD services: Colorado, Delaware, Illinois, Maine, and New York), with DRUG POL’Y & PUB. STRATEGIES CLINIC, supra note 111, at 5–8, 10 (revealing only three states adopted provider-to-enrollee ratios or minimum-number-of-providers requirements for mental health and SUD services by August 2016: Colorado, Delaware, and Maine).
136. HALL & GINSBURG, supra note 58, at 22 (“To ensure the adequacy of provider networks, neither general qualitative standards (‘sufficient to avoid unreasonable delay’) nor quantitative standards (specified capacity, provider distribution, or wait times) are sufficient, either alone or in combination. Qualitative standards are too general to be self-enforcing, and quantitative standards can be too complex or inflexible. Both kinds of standards are designed more for threshold entry into the market as a whole than for resolving patients’ rights in particular cases.”), Compare LEGAL ACTION CTR., supra note 110, at 1 (“Twenty-nine . . . states have adopted at least one quantitative metric to define network adequacy for state-regulated private insurance plans.”), with MELEK ET AL., supra note 12, at 4 fig.4 (showing high rates of out-of-network utilization throughout the United States).
138. HALL & GINSBURG, supra note 58, at 4 exhibit 1.
139. Id. at 9 (“Another difficulty presented by quantitative standards is determining what is the appropriate standard. There is not a clear evidence-based consensus on what provider-population ratios, drive times, or wait times are minimally adequate.”); Zhu et al., supra note 17, at 1630.
Sparse application and nearly nonexistent enforcement have rendered quantitative requirements largely ineffective. Further, critics of the quantitative approach have pointed out that quantitative limitations “may only demonstrate that a network is adequate at one point in time and may not adequately account for geographic and provider variability.” Whatever their flaws, these three quantitative measures serve as some of the few tools and guidelines for evaluating and enforcing behavioral network adequacy with specificity. They do not provide the only tools, however, for addressing access to care.

3. “Any Willing Provider” Laws

In addition to quantitative standards, over half of the states have passed AWP laws to combat shortages and irregular distribution of many kinds of providers. AWP laws prohibit networks from excluding or refusing services from any provider located in the geographical area covered by the plan so long as “the provider is willing to meet the terms and conditions for participation established by the health insurer.” Perhaps due to the particular provider

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140. See LEGAL ACTION CTR., supra note 110, at 17 (“Even in states with quantitative standards, most states rely on only one quantitative metric, and some do not apply standards uniformly to various insurance products. Further, most states do not engage in rigorous, ongoing monitoring or taking meaningful enforcement actions.”).

141. Id. at 15.

142. See Busch & Kyanko, supra note 64, at 981 (“To assess whether insurers have provided patients with sufficient in-network providers, states rely on a variety of network adequacy measures, ranging from geographic access, provider-to-enrollee ratios, and timely access standards.”); JOANN VOLK, MAANASA KONA, MADELINE O’BRIEN, CHRISTINA LECHNER GOE & JAMES MAYHEW, CAL. HEALTH CARE FOUND., EQUAL TREATMENT: A REVIEW OF MENTAL HEALTH PARITY ENFORCEMENT IN CALIFORNIA 18 (2020), https://www.chcf.org/wp-content/uploads/2020/07/EqualTreatmentMentalHealthParityCalifornia.pdf [https://perma.cc/N86C-LWNF] (“Regulators in California review provider networks for compliance with regulatory standards regarding timely access to appointments, geographic access, and ratios of providers to enrollees, but they do not currently review provider networks for compliance with [the Mental Health Parity and Addiction Equity Act’s (MHPAEA)] [nonquantitative treatment limitation (NQTL)] requirements.”).


shortages in rural areas, a nearly complete overlap exists between the states that have passed AWP laws and the most rural states in the country.146

Proponents of AWP laws have argued that the laws protect patient choice and ensure that consumers have access to the highest quality providers.147 These laws have been fiercely challenged, however, for undermining one of the central cost-saving tenets of narrow networks: insurers’ ability to negotiate better prices with providers in exchange for a higher volume of patients.148 Opponents argue that AWP statutes weaken insurers’ bargaining power by stripping them of control over the breadth of their networks.149 Further, these laws tend to weaken competition among insurers in a given area by disincentivizing competitive pricing.150 Unsurprisingly, providers tend to favor these statutes the most, and critics argue the laws have done more to help providers than to increase access for patients.151

Yet the impact of AWP statutes on the field of behavioral health appears limited; although some states employ broad AWP laws, most apply only to pharmacies or pharmacists.152 To date, very few states

PAYP] (listing twenty-seven states that had passed “any willing provider” laws (AWP) by 2014); e.g., VT. STAT. ANN. tit. 8, § 4089b(c)(2) (2020).
146. Sukel, supra note 137 (discussing the “acute” shortage of primary care providers in rural areas). Compare Noble, supra note 145 (listing states that had passed AWP laws by 2014), with Rural States Are Almost Entirely Ignored Under Current State-by-State System, NAT’L POPULAR VOTE [hereinafter Rural States Almost Entirely Ignored], https://www.nationalpopularvote.com/rural-states-are-almost-entirely-ignored-under-current-state-state-system [https://perma.cc/T4C4-REYE] (cataloging the most rural states in the country according to data from the 2010 census). Since 2014, Vermont, the second most rural state in the nation, has also passed its own behavioral-care-specific AWP law. § 4089b(c)(2); Rural States Almost Entirely Ignored, supra.
147. Blake, supra note 57, at 99 n.209.
148. HALL & GINSBURG, supra note 58, at 5–6 (“[AWP] laws make it difficult for insurers to funnel a greater volume of patients to a smaller set of select providers as a way to negotiate the best prices.”); Anderman, supra note 50 (“[I]nsurers that offer [narrow network plans] work with a smaller pool of doctors, hospitals, and treatment centers, who agree to a lower price for services with the expectation that they will get greater patient volume.”).
150. William J. Bahr, Although Offering More Freedom to Choose, “Any Willing Provider” Legislation Is the Wrong Choice, 45 U. KAN. L. REV. 557, 585 (1997) (“[AWP] statutes undermine the incentive of managed care organizations to set competitive prices. . . . Thus, a state that adopts any [AWP] statutes will have less competition among the managed care organizations.”).
151. HALL & GINSBURG, supra note 58, at 5–6; Blake, supra note 57, at 99 n.209.
152. FOX ET AL., supra note 143, at § 11.37 (“Although some state statutes apply across the board to a
seem to have passed AWP laws that specifically encompass behavioral health care providers. The effects of a broad AWP statute, however, may bleed over into the area of behavioral health if the state also mandates that insurers offer either minimal or optional behavioral health coverage.

4. Behavioral Health Care Providers’ Low Reimbursement Rates and Network Participation

Even if AWP statutes were more frequently applied to behavioral health, their limitation might swallow the rule: behavioral health care providers often do not seem willing to meet insurers’ terms and conditions. So far, regulations have been unable to guarantee insurance reimbursement rates that adequately incentivize behavioral health care providers to participate in insurance networks. The financial equation, which includes market conditions that further stack the deck against participation, explains behavioral health care providers’ eschewal of insurance networks: they stand to profit more by staying out. As a result, many behavioral health care providers

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153. See, e.g., V.T. STAT. ANN. tit. 8, § 4089b(c)(2) (2020); see also Baird, supra note 152 (noting West Virginia’s AWP statute as the only of twenty-seven to apply specifically to behavioral health care providers, though Wyoming’s applies to all providers).

154. Compare Richard Cauchi & Karmen Hanson, Mental Health Benefits: State Laws Mandating or Regulating, NAT’L CONF. OF STATE LEGISLATURES (Dec. 30, 2015), https://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx [https://perma.cc/NLSU-KJXH] (describing “[m]any state laws require that some level of coverage be provided for mental illness, serious mental illness, substance abuse or a combination thereof”), with Baird, supra note 152 (illustrating how AWP provisions of states like Alabama, Georgia, Mississippi, and Utah apply more broadly than the provisions of other states), and FOX ET AL., supra note 143, at ¶ 11.37 (“[S]ome state statutes apply across the board to a broad array of providers . . . .”).

155. See generally Zhu et al., supra note 17 (reporting disproportionately low rates of network participation among behavioral health care providers compared to primary care physicians).

156. See infra Part II.A.4.

opt not to participate in any insurance networks whatsoever. In other words, these providers only accept clientele who can afford to pay out of pocket. A predominantly self-funded model poses obvious difficulties for low-income individuals and diminishes access to services for individuals who may need it most.

The financial dynamic for psychiatrists stems from failed reimbursement regulations and several market factors. First, more psychiatrists choose to own their own practice than do physicians from any other discipline. Unsurprisingly, these high rates of ownership flow from the potential to earn higher salaries: psychiatrists stand to make more money as solo practitioners than with any other established medical group or hospital. Although solo practices present obvious

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158. Volk et al., supra note 142 (“[L]ow reimbursement rates . . . discourage [behavioral health care] providers from participating in networks.”); Zhu et al., supra note 17. In the Zhu, Zhang & Polsky study, only 21.4% of mental health providers participated in an ACA Marketplace network. Id. at 1627.

159. Honberg et al., supra note 11, at 3 (“Compounding the problem of mental health workforce shortages is the reality that many practicing psychiatrists do not accept health insurance, confining their clientele to people with the resources to pay out of pocket. A recent study published in JAMA Psychiatry revealed that only 55% of psychiatrists accepted insurance in 2009–2010 as compared to 88.7% among physicians in other medical specialties.”).


161. See infra Part II.A.4.


163. Carol Peckham, Medscape Psychiatrists Compensation Report 2015, MEDSCAPE (Apr. 21, 2015), https://www.medscape.com/features/slideshow/compensation/2015/psychiatry#page=10 (https://perma.cc/BU3H-MQLJ) (“Psychiatrists in office-based solo practices make the most ($252,000), followed by multispecialty groups ($229,000). Those who earn the least money are in academic or government centers ($188,000) and hospitals ($207,000),”). The trends in the salaries of solo-practitioner psychiatrists do not apply equally across all types of physicians. See, e.g., Jai Parekh & David Goldman, Group Practice vs. Solo Practice, HEALTH (Mar. 26, 2015),
benefits for psychiatrists, the benefits are less obvious for their patients. Partly due to having fewer staff to handle insurance billing, solo practitioners accept insurance more infrequently than any other kind of psychiatric practice.

Further, due to the nature of psychotherapy, psychiatry appointments last longer than other types of medical visits, meaning psychiatrists cannot see as many patients per day—and thus cannot bill for as many services—as other providers. But high demand for psychiatric services leaves psychiatrists free to see only those patients who can afford to pay out of pocket rather than deal with the cumbersome documentation necessary for insurance billing processes. Indeed, providers cite “onerous health plan processes for authorizing payment” and “burdensome contracting terms” as major deterrents of network participation.

See Tara F. Bishop, Matthew J. Press, Salomeh Keyhani & Harold Alan Pincus, Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, 71 J. AM. MED. ASS’N PSYCHIATRY 176, 179 (2014) ("[In a study], [p]sychiatrists in solo practice were less likely to accept all types of insurance . . . .")

Id. at 180 ("Solo practices often can function with much less infrastructure than larger single-specialty or multispecialty group practices. As a result, they may have little incentive to hire staff to interact with insurance companies."). Most psychiatrists already spend ten hours or more per week doing administrative work and thirty-three hours seeing patients, so psychiatrists may simply find it impracticable to jump through more hoops to receive insurance reimbursements. Leslie Kane, Medscape Psychiatrist Compensation Report 2019, MEDSCAPE (Apr. 24, 2019), https://www.medscape.com/slideshow/2019-compensation-psychiatrist-6011346# (indicating that male psychiatrists spend an average of thirty-four hours per week seeing patients, as compared to thirty-two hours per week among female psychiatrists); id. (indicating that 40% of psychiatrists spend between ten and nineteen hours doing administrative work per week, and 37% spend twenty hours or more on the same tasks).

Bishop et al., supra note 164, at 180 ("Primary care physicians probably can see and provide management to patients in shorter visits . . . . than psychiatrists, especially if psychiatrists want to provide psychotherapy along with medication management. As a result, psychiatrists may not be able to see as many patients in a day as physicians in other specialties.").

Id. ("A shortage of psychiatrists may also be a potential reason why many do not accept insurance. . . . [D]eclines [in the number of graduates from psychiatry training programs] coupled with an aging workforce (55% of psychiatrists are aged 55 or older) may mean that the supply of psychiatrists cannot meet the demand for their care.").

VOLK ET AL., supra note 142, at 16.
Reimbursement rates probably comprise the most burdensome of those contracting terms. Participating providers receive reimbursement at much lower rates than their primary care and specialist counterparts. Insurers reimburse in-network behavioral health care providers at lower rates relative even to Medicare-allowed amounts, which provide an industry-recognized benchmark that most primary care doctors’ and specialists’ rates exceed.

Notably, reimbursement rate disparities persist despite falling under the purview of the MHPAEA regulation of nonquantitative treatment limitations (NQTLs). MHPAEA regulations, in adherence to the MHPAEA’s core principle, require that reimbursement rates for behavioral health care providers must be comparable to reimbursement rates for other types of providers. Although reimbursement disparities are not themselves parity violations, they constitute “red flags” that may indicate a parity violation in need of enforcement oversight. In addition to enforcement-related factors, the failure of legislative efforts to normalize reimbursement rates, to date, can also be attributed to varying practices and views among payers and providers.

To begin with, some payers cite an inability to rely on the same methodologies they use to determine reimbursement rates for medical and surgical services when deciding rates for behavioral health care services—differing procedures likely influence differing reimbursement methodologies.
reimbursement levels.\textsuperscript{176} Further, providers and payers may hold differing views on how long inpatient behavioral health stays should reasonably last without prior authorization, making compromises on reimbursement terms more elusive.\textsuperscript{177} Additionally, and somewhat nonsensically, the billing methods that insurance companies use to reimburse behavioral health care services can result in lower payments to psychiatrists than to other types of medical doctors who render these services.\textsuperscript{178} These diverging practices and views predictably contribute to diverging reimbursement rates.\textsuperscript{179}

On the enforcement side, disparate reimbursement rates should prompt a review of insurers’ reimbursement methodologies, but confusion seems to exist among some state and local regulators about whether they possess the authority to do so.\textsuperscript{180} Even where regulators feel secure in their authority, the industry seems unaware of how to actually conduct these reviews; reimbursement compliance can be difficult to assess, particularly in states that do not generally reimburse on a fee-for-service basis.\textsuperscript{181} Thus, following the theme of qualitative and quantitative network adequacy standards, efforts to ensure

\textsuperscript{176} See id. (“One payer stated that for medical/surgical services, hospitals usually rely on diagnostic-related groups (DRGs) to establish in-patient reimbursement rates based on long-standing calculations, but because DRGs do not exist for [mental health and SUD] benefits, payers are more reliant on utilization management to determine payment.”).

\textsuperscript{177} Id. (“One provider noted that it would be reasonable . . . to allow for a seven-day hospital stay for mental health conditions without prior authorization; however, others expressed the opposite view. A payer said standardizing care by imposing minimum stays would remove the incentive to provide individualized care . . . .”).

\textsuperscript{178} Nicole M. Benson & Zirui Song, Prices and Cost Sharing for Psychotherapy in Network Versus out of Network in the United States, 39 HEALTH AFFS. 1210, 1215 (2020) (“[I]nsurance reimbursement to behavioral health providers for behavioral health services, largely billed using evaluation and management codes[,] . . . can be less favorable than for peer specialties. For example, in 2014 the median in-network reimbursement for a midlevel office visit . . . for a commercially insured patient was $76 for a nonpsychiatrist medical doctor compared with $66 for a psychiatrist.”).

\textsuperscript{179} See MELEK ET AL., supra note 12, at 2, 5 fig.5.

\textsuperscript{180} VOLK ET AL., supra note 142, at 18 (“Regulators at [the California Department of Managed Health Care] . . . indicated that they do not have the authority to review provider reimbursement rates. Their authority to enforce MHPAEA, however, may provide inherent authority to review provider reimbursement rates for NQTL compliance.”).

\textsuperscript{181} TARA ADAMS RAGONE & JOHN V. JACOBI, BRIEFING REPORT: THE PUZZLE OF PARITY: IMPLEMENTING BEHAVIORAL HEALTH PARITY 11 (2017), https://ssrn.com/abstract=2917400 [https://perma.cc/BZ2M-9D3J] (“None of the well more than 100 people attending the [Sentinel Project’s September 16, 2016, conference examining market responses to the ACA’s expansion and redefinition of coverage] was able to suggest how the NQTL test applies to these varying reimbursement structures.”).
reimbursement parity seem hampered by inadequate oversight and enforcement. Without strong financial or regulatory incentives, low network participation will continue.\textsuperscript{182} Moreover, regulators remain frustrated in their attempts to conduct reimbursement compliance reviews due to other weak or nonexistent regulations that govern the accuracy of insurance networks’ provider directories.\textsuperscript{183}

5. \textit{Inaccurate Provider Directories}

At first glance, the causal relationship between inaccurate directories and inadequate networks might not seem readily apparent.\textsuperscript{184} The two may often coexist within a given plan, but an inaccurate directory negates even the expansive patient-choice benefits of broad networks.\textsuperscript{185} Closer examination of enforcement methods, however, reveals a surprising causal relationship: inaccurate directories perpetuate network inadequacy.\textsuperscript{186} Regulators often depend on provider directories to conduct reviews of a plan’s compliance with network adequacy regulations, so discrepancies can cause oversight of inadequacies.\textsuperscript{187}

The results of erroneous directories, however, reach more than just regulators; these errors affect behavioral health patients and other patients alike.\textsuperscript{188} One study revealed one PPO’s directory as having

\textsuperscript{182} \textit{See id.}
\textsuperscript{183} \textit{See Busch & Kyanko, supra note 64, at 975, 978. “[R]egulators . . . may rely on directory information to determine whether a plan has an adequate network.” Id. at 975.}
\textsuperscript{184} \textit{See id. “[T]he authors of a survey assessing directory inaccuracies] considered whether patients who encountered [directory] inaccuracies filed a complaint about the mental health network.” Id. at 976 (emphasis added). “Associations between directory inaccuracy and use of out-of-network care may also be indicative of mental health network inadequacy . . . .” Id. at 981 (emphasis added).}
\textsuperscript{185} \textit{See Anderman, supra note 50 (“[P]lans with broad networks are likely to have upwards of 70[\%] of local providers participating.”).}
\textsuperscript{186} \textit{Busch & Kyanko, supra note 64, at 981 (“To assess whether insurers have provided patients with sufficient in-network providers, states rely on a variety of network adequacy measures. . . . In turn, many of these measures rely on directory data.”).}
\textsuperscript{187} \textit{Id.}
\textsuperscript{188} \textit{Compare id. at 978 (“Fifty-three percent of participants who had used a mental health directory reported encountering at least one of the four directory problems in the past twelve months.”), with Michael Adelberg, Austin Frakt, Daniel Polsky & Michelle Kitchman Strollo, \textit{Improving Provider Directory Accuracy: Can Machine-Readable Directories Help?}, 25 AM. J. MANAGED CARE 241, 241 (2019) (“A recent report from [the Centers for Medicare and Medicaid Services (CMS)] found that 52\% of providers in [Medicare Advantage (MA)] provider directories included at least [one] inaccuracy.”).}
inaccurate phone numbers for nearly one out of five psychiatrists.\(^{189}\) Overall, 22% of the calls made in the study were to wrong numbers.\(^ {190}\) In another study, over half of mental health patient-participants reported encountering one of the four directory inaccuracies that comprised the survey’s focus.\(^ {191}\) The study found a significant association between incorrect directories and out-of-network utilization, which may indicate network inadequacy.\(^ {192}\)

Although federal law requires Medicaid-managed care, Medicare Advantage, and Marketplace plans to regularly update their directories, no comparable federal protections apply to the commercial insurance held by the majority of Americans.\(^ {193}\) Fewer than half of the states require private plans to provide up-to-date directories.\(^ {194}\) Recently, insurers have taken innovative steps to help increase their compliance with directory regulations.\(^ {195}\) But the steps necessary for compliance are divergent: in accordance with the common theme among state-level network adequacy regulations, state requirements vary on a number of fronts.\(^ {196}\)

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189. Malowney et al., supra note 68, at 94–95 (“[Sixteen percent] of the numbers in the BCBS database were wrong; they included numbers for a McDonald’s restaurant, a boutique, and a jewelry store.”).

190. Id. at 95 tbl.1.

191. Busch & Kyanko, supra note 64, at 978.

192. Id. “Experiencing inaccuracies with the directory was significantly associated with use of out-of-network providers. . . . Among participants who encountered any of the four kinds of directory inaccuracies studied, 40[percent] were treated by an out-of-network provider in the past year, compared with 20[percent] among those who did not encounter directory inaccuracies.” Id. (citation omitted). “Associations between directory inaccuracy and use of out-of-network care may also be indicative of mental health network inadequacy, which is a problem [because] psychiatrists are less likely than other physicians to participate in private insurer networks.” Id. at 981.

193. Id. at 981.

194. Id.


196. Busch & Kyanko, supra note 64, at 981 (“Approximately twenty states have requirements directly related to directory accuracy for private plans, though these state laws vary in how often the directories must be updated, the types of plans covered (for example, health maintenance organizations and preferred provider organizations), and the content required.”).
Moreover, mistaken out-of-network utilization resulting from directory inaccuracies has previously led to surprise medical bills.197 Some states paved the way for the recent federal ban on surprise billing by passing bans of their own.198 Opponents of these bans have argued that the laws diminish networks and “adversely [affect] patients’ access to in-network care.”199 These claims appear unsubstantiated, however, and at least one state saw a decrease in out-of-network utilization for affected specialties after it passed a no surprise billing law.200 Nonetheless, another problem inhibits legislators’ efforts to ensure behavioral health care providers’ adequate representation in insurance networks: not enough exist.201

B. Provider Shortages

Shortages of mental health care providers are rampant throughout every state and territory in the United States.202 Over one third of the

199. Adler et al., supra note 197. Opponents of California’s surprise billing law claimed that the law reduced provider participation in insurance networks:

[The] void [in data created by the novelty of surprise billing laws] leaves a lot of room for unsubstantiated claims by stakeholders. The California Medical Association (CMA) published a public letter in July [2019] urging federal lawmakers to avoid California’s payment standard approach, asserting that it had diminished networks and reduced access to specialty care in California. . . .

. . . . [The CMA asserts that] “[u]nder California’s surprise billing law[,] . . . patient complaints about access to care have increased by almost 50%.”

Id.

200. Id. ("[T]he CMA does not cite empirical research supporting any of [its] assertions [that California’s surprise billing law has diminished networks]. . . . [The authors] observ[ed] a 17% decline in the share of services delivered out-of-network . . . .").

201. See infra Part II.B.
202. See Mental Health Professional Shortage Areas Table, supra note 64; see also Mental Health Care Health Professional Shortage Areas (HPSAs), KAISER FAM. FOUND., https://www.kff.org/other/state-
2022]  

404 PROVIDER NOT FOUND

United States’ population lives in a Health Professional Shortage Area (HPSA) for mental health care providers. HPSA designations, which fall under the purview of the Health Resources and Services Administration (HRSA), indicate a population-to-provider ratio of at least thirty thousand to one for mental health services.

Of the psychiatrists in the United States, an estimated one in five does not accept new patients. Estimates for Marketplace plans in certain parts of the country have put the percentage far lower. These assessments, along with long appointment wait times, suggest that the available supply of behavioral health care providers finds itself stretched thin.

Although markers of an inadequate supply of behavioral health care providers may be found throughout the country, rural areas tend to feel the effects of behavioral health shortfalls most acutely. Rural shortages are especially troublesome because people living in rural areas are as likely—or even more likely—to suffer from mental health conditions and SUDs than individuals in urban areas.

[Web link]
infrastructure compounds the effects of shortages on rural residents’ ability to locate providers, and unequal distributions of behavioral health care providers throughout rural states contribute to the long distances that these residents must often traverse in search of care.\textsuperscript{210} To address the behavioral health workforce shortage and mitigate its effects, federal and state governments use financial incentive programs to boost recruitment and telehealth services to bridge geographic divides.\textsuperscript{211}

\textit{1. Scholarships and Loan Repayment Programs for Medical Students}

Currently, the federal government offers student loan forgiveness and loan repayment programs (LRPs) via the military and a wide array of federal agencies.\textsuperscript{212} LRPs and scholarships provide strong incentives for students to enroll in medical school.\textsuperscript{213} These programs repay some or all medical school loans in exchange for any one of a variety of post-graduation commitments, which include engaging in research or public service, serving in the military, or agreeing to practice in an HPSA for a fixed period.\textsuperscript{214} In addition to federal programs, states administer their own similar LRPs, and the American Psychological Association (APA) provides a search engine on their website for “more than 600 scholarships, grants, and awards sponsored

\textsuperscript{210} See id. at 2; see also, e.g., CHIEDI, supra note 71, at 8 (depicting New Mexico’s uneven distribution of behavioral health care providers geographically). “[New Mexico’s] 2,665 licensed behavioral health providers are distributed unevenly across the State.” Id. at 7.

\textsuperscript{211} See infra Part II.B.


by the APA and other psychology-related organizations.”

One of these federal programs, Public Service Loan Forgiveness (PSLF), requires students to work for ten years at an eligible organization and make 120 payments toward their student loans before forgiving their remaining balance. Although the federal government intended the program to encourage students to enter fields such as teaching and firefighting, physicians have increasingly entered medical school intending to enroll in PSLF. The program does little, however, to target workforce shortages in specific disciplines or geographical areas: most doctors qualify through working at nonprofit hospitals, which comprise roughly three quarters of the nation’s hospitals.

In recent years, politicians have proposed maximum forgiveness limits on the PSLF program or eliminating it entirely.
explanation for this hostility comes from the origins of the program: politicians originally designed PSLF with low-paying, high-demand career choices in mind.221 Although the medical profession certainly satisfies the latter criterion, it does not so much satisfy the former; physicians’ salaries in all disciplines typically reach six figures.222

Additionally, the National Health Service Corps (NHSC), another federal program, provides scholarships and LRPs in exchange for practitioners’ agreements to serve in HPSAs.223 Conducted by HRSA, these programs provide financial assistance to medical students in a range of eligible disciplines, including mental health and SUD specialists.224 NHSC programs appear quite competitive.225

Their selectivity notwithstanding, NHSC programs have apparently seen success in increasing the supply of behavioral health care providers.226 Unlike PSLF, these programs specifically target behavioral health.227 Further, these and other programs administered by HRSA, such as the Title VII Behavioral Health Workforce Education and Training Program (BHWET) for professionals, have recently seen considerable funding increases.228

221. Helhoski & Beresford, supra note 218.
223. NHSC Loan Repayment Program, supra note 212.
225. HRSAtube, Factors for Determining an NHSC Award, YOUTUBE, at 01:07–01:18 (Dec. 9, 2015), https://www.youtube.com/watch?v=De4lAHqOq&feature=emb_title (“Each year, [National Health Service Corps (NHSC)] programs receive many eligible applications, so it is a competitive award process.”); see also Budd, supra note 212 (“Witt was turned down for an NHSC scholarship . . . .”).
226. See Building Healthier Communities, supra note 213. According to NHSC data, its scholarships and loan repayment programs (LRPs) have doubled the number of SUD clinicians nationwide and the “mental and behavioral health total field strength [has] increased by more than 40%.” Id. Of the more than 16,000 providers participating in the NHSC programs in 2020, more than 2,500 are mental and behavioral health clinicians practicing in rural areas. Id.
227. See id.; see also, e.g., NHSC Substance Use Disorder Workforce Loan Repayment Program, supra note 224.
228. HEALTH RES. & SERVS. ADMIN., FISCAL YEAR 2021: JUSTIFICATION OF ESTIMATES FOR
Fortunately, policy analysts expect that current efforts will lessen the projected shortage of behavioral health care providers.\textsuperscript{229} Despite the quantifiable success of NHSC programs to date and the recent expansion of federal funding—the effects of which have yet to be fully realized—HRSA still currently designates the vast majority of the land area in the United States and its territories as HPSAs for mental health, which indicates a gap still in need of closing.\textsuperscript{230}

2. The Use of Telehealth Services and Integrated Care Models

Telehealth, a broad term that encompasses the narrower “telemedicine,” constitutes an important tool in the toolkit for combatting the shortfall of health care providers.\textsuperscript{231} Telehealth uses internet and cellular communications technologies, both in real time and asynchronously, to remotely deliver “health information and treatments” to both patients and providers.\textsuperscript{232} In other words, although telemedicine encompasses only services to patients, telehealth also...
encompasses training for health care professionals and the exchange of ideas among them.233

The health care industry has employed behavioral telehealth services to perhaps its greatest effect in behavioral care integration and collaborative care models.234 Despite some differences, these frameworks rest on the same premise: integrating behavioral health specialists’ insight into patients’ routine primary care can alleviate the effects of the behavioral workforce shortage and supply cost-effective behavioral care to more people.235 By using telehealth to connect with primary care doctors, psychiatrists can oversee treatment for many more patients per day.236 Due to more frequent contact with patients, primary care physicians often find themselves in a better position for early detection of behavioral health conditions.237 Evidence shows that early treatment of mental health conditions can save enormous health

233.  What is Telehealth? How Is It Different from Telemedicine?, supra note 231.
234.  See Jürgen Unützer, Henry Harbin, Michael Schoenbaum & Benjamin Druss, CTR. FOR HEALTH CARE STRATEGIES, THE COLLABORATIVE CARE MODEL: AN APPROACH FOR INTEGRATING PHYSICAL AND MENTAL HEALTH CARE IN MEDICAID HEALTH HOMES I (2013), https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf (https://perma.cc/66E5-Q26U) (“More than [seventy] randomized controlled trials have shown collaborative care for common mental disorders such as depression to be more effective and cost-effective than usual care, across diverse practice settings and patient populations.”).
235.  Brittany H. Eghaneyan, Katherine Sanchez & Diane B. Mitschke, Implementation of a Collaborative Care Model for the Treatment of Depression and Anxiety in a Community Health Center: Results from a Qualitative Case Study, 7 J. MULTIDISCIPLINARY HEALTHCARE 503, 503 (2014) (“The collaborative care model is a systematic approach to the treatment of depression and anxiety in primary care settings that involves the integration of care managers and consultant psychiatrists, with primary care physician oversight, to more proactively manage mental disorders as chronic diseases, rather than treating acute symptoms.”).
236.  Id. at 508 (“The collaborative care team members used various forms of communication with each other. Emails, messaging via the EHR system, telephone calls, and in-person meetings were all ways in which communication about patients within the program was conducted.”); ERIK R. VANDERLIP, JAMES RUNDSELL, MARC AVERY, CAROL ALTER, CHARLES ENGEL, JOHN FORTNEY, DAVID LIU & MARK WILLIAMS, DISSEMINATION OF INTEGRATED CARE WITHIN ADULT PRIMARY CARE SETTINGS: THE COLLABORATIVE CARE MODEL 10 (2016) (“For models integrating mental health into primary care, mental health providers can impact the care of more patients than in the specialty mental health referral sector. Integrated mental health providers take on more consultative and team-based roles and focus on helping primary care providers (PCPs) treat mental health disorders, leveraging their skills and expertise to reach more patients in need.”).
care costs in the long run and that integrated care models effectively address these conditions.\textsuperscript{238}

Further, the nature of many behavioral health care services makes them particularly amenable to direct delivery via telemedicine.\textsuperscript{239} For example, psychiatrists conduct psychiatric interviews, which comprise a fundamental part of diagnostic procedures, to identify behavioral conditions and prescribe treatment, and the conversational nature of a patient interview renders it particularly well suited for video conferencing.\textsuperscript{240} Although improvements in imaging technology, lab tests, and the understanding of the link between mental health conditions and physical ailments have increased the use of physical exams and tests about diagnoses of mental health conditions, psychiatric interviews remain a key component of the process.\textsuperscript{241}

By virtue of telehealth’s ability to bridge geographical divides, rural areas stand to benefit significantly from its use.\textsuperscript{242} Telemedicine allows rural patients to seek behavioral treatment confidentially, ameliorating privacy concerns specific to rural communities.\textsuperscript{243} Further, integrated


\textsuperscript{239} See, e.g., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., supra note 209, at 5 (“The U.S. Department of Veterans Affairs piloted a substance use treatment program using an in-home messaging device (IHMD), a hand-held device that connected to a telephone outlet... Clients used the IHMD every day to access a combined behavioral intervention (CBI) for [SUDs], CBI is a blend of cognitive-behavioral therapy, [twelve]-Step approaches, and motivational interviewing.”).

\textsuperscript{240} See Daniel Lin, Jason Martens, Agnieszka Majdan & Jonathan Fleming, Initial Psychiatric Assessment: A Practical Guide to the Clinical Interview, 45 B.C. MED. J. 172, 172 (2003), https://bcmj.org/articles/initial-psychiatric-assessment-practical-guide-clinical-interview#2 [https://perma.cc/5UC5-E4WR] (“It is widely accepted that clinical interviewing is the fundamental diagnostic tool in psychiatry... Unlike other areas of medicine, psychiatry lacks external validating criteria, such as lab tests or imaging, to help confirm or exclude diagnoses.” (citations omitted)).


\textsuperscript{242} See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., supra note 209, at 4 (“The single area where improved [rural] patient care could be realized is in the significant expansion and active use of telehealth.”).

\textsuperscript{243} Id. at 3. Telehealth addresses privacy concerns that crop up in rural communities in several ways:
care models have the capacity to connect behavioral health specialists from anywhere in the country to rural nonspecialists for both training and case consultation.\footnote{Id. at 2–3.}

Poorly developed communications infrastructures in many rural communities, however, currently limit the potential of telehealth to fill the behavioral gaps in those areas.\footnote{Id. at 5 (“Internet access remains a challenge to rural telehealth.”).} In recent years, the federal government has spent billions of dollars on improving rural internet infrastructure as part of programs like the Connect America Fund.\footnote{Id.; 47 C.F.R. § 54 (2020).} Some have criticized these investments as inefficient, however, and current progress seems limited.\footnote{Scott Wallsten, \textit{Rural Broadband Subsidies: The Gift that Keeps on Giving}, TECH. POL’Y INST. (Jan. 22, 2018), https://techpolicyinstitute.org/2018/01/22/rural-broadband-subsidies-the-gift-that-keeps-on-giving/ [https://perma.cc/4MJT-TTJ5] (“[F]ederal rural broadband subsidies are not working, and we should fix the problems instead of making them bigger. . . . [O]verhead costs take up about 60[\%] of subsidies sent to rural providers, displacing potentially productive investment.”).} In 2015, nearly one quarter of rural households lacked basic broadband service entirely, and 39\% lacked access to advanced broadband.\footnote{US SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., supra note 209, at 5.} Limited bandwidth means limited availability of telehealth services.\footnote{Id. at 6.}

In addition to receiving-end connection issues, providers of behavioral telehealth face their own challenges.\footnote{Id.} First, telehealth
programs can be initially expensive to implement. In addition to high startup costs, ensuring patient security and privacy requires data encryption and network firewalls, which in turn require technical support. Any technical problems that do arise can lead to disruptions in treatment. Further, providers must educate themselves on a state’s licensing laws before delivering telehealth services to patients in that state, and variations in these laws can make the process confusing, costly, and time-consuming for providers.

Unfortunately, state licensing laws do not comprise the only source of headache-inducing variability for providers of behavioral telemedicine. States across the country have increasingly enacted telehealth commercial payer statutes in recent years, which aim to expand access to telehealth services by making them more affordable for patients and providers alike. Much like the disparities seen in state-level mental health parity laws, however, the strength and efficacy of these laws vary widely from state to state. Although many of the statutes mandate coverage for telehealth services, some do not, which negatively impacts consumers. Some of these laws seek to expand access to telehealth by requiring some form of reimbursement parity between in-person and remote delivery of the

251. Id. at 7.
252. Id.
253. Id. at 6.
254. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., supra note 209, at 6.
257. LACKTMAN ET AL., supra note 255, at 2.
258. See id. ("Of the forty-three states that maintain a telehealth commercial payer statute[,] three states have telehealth coverage laws on the books that do not actually mandate health plans to cover services delivered via telehealth (Florida, Illinois, and Michigan.").

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same services.259 Only a few states mandate payment parity, however, and even fewer offer “true ‘payment parity[,]’” which negatively impacts providers.260 Although trends have been positive, roadblocks to telehealth still remain.261

C. The Sum of Provider Shortages and Inadequate Network Adequacy Regulations

In sum, the word “patchwork” more than aptly describes the supply of behavioral health care providers and the state and federal network adequacy regulations promulgated to date.262 When viewing network adequacy regulations and provider shortages alongside one another, the holes in the patchwork become abundantly clear.263 Fortunately, however, light shines through, and examination of these failures illuminates opportunities for improvement.

III. PROPOSAL

To overcome access disparities in behavioral health care, governments should follow a three-pronged approach. First, regulators should bolster key insurance regulations, namely those governing reimbursement rates and provider directories, and enforce existing network adequacy regulations more strongly.264 Second, Congress should provide tax incentives for psychiatrists to accept insurance, especially Medicaid.265 Third, loan repayment assistance, expanded scopes of practice, educational programs, and telehealth services must

259. Id.
260. See id. (“Currently, [twenty-two] states maintain laws expressly addressing reimbursement of telehealth services[,] . . . [but only fourteen] of [them] offer true ‘payment parity[,]’ . . . meaning that providers outside those [fourteen] states may find they receive lower payment for telehealth-based services compared to in-person services (i.e., same service code, but different reimbursement rates).”).
261. Id.
262. GOODELL, supra note 13, at 4.
263. See generally MELEK ET AL., supra note 12 (demonstrating high out-of-network utilization for behavioral health care patients and disparate insurance reimbursements for behavioral health care providers).
264. See infra Part III.A.
265. See infra Part III.B.
bridge the gap between supply and demand for behavioral health care providers.266

A. Strengthen and Enforce Network Adequacy Regulations for Behavioral Health

To increase behavioral providers’ presence in insurance networks, regulators should narrowly impose quantitative reimbursement standards for behavioral health care services while capping allowable out-of-network charges for those same services.267 Further, although states should consider enacting stronger network adequacy standards more widely, regulators should first bolster enforcement of network adequacy standards by implementing review processes that focus on patient outcomes.268

1. Establish Quantitative Reimbursement Requirements

Behavioral health care providers frequently cite low reimbursement as a primary driver of their decisions not to participate in insurance networks.269 To increase behavioral health specialists’ participation in insurance networks, federal regulations should—accounting for variation by plan type and geographical differences in health care prices—establish quantitative reimbursement baselines for federally regulated plans in two areas of behavioral health treatment: (1) the treatment of severe mental illness (SMI), and (2) integrated care. For state-regulated plans, the federal government should require states to adopt their own quantitative reimbursement standards, and if they do not, the federal baseline will serve as the fallback standard. Additionally, lawmakers should raise reimbursement rates in these two

266. See infra Part III.C.
267. See infra Part III.A.1.
268. See infra Part III.A.2. Mark A. Hall and Paul B. Ginsburg have proposed a partially outcome-based approach: “[A] thoroughgoing regulatory approach demands considerable administrative resources. In attempting to reduce the complexities of regulating the structure of provider networks, we might instead consider whether the regulatory focus should be on the ultimate outcome of network adequacy: achieving actual access to care.” HALL & GINSBURG, supra note 58, at 20.
269. E.g., Benson & Song, supra note 178 (“[D]eclin[ing] in-network prices over time . . . may discourage [mental health] providers from participating in insurance networks; for example, psychologists have reported low reimbursement rates as a primary deterrent to participating in Medicare.”).
areas for public programs such as Medicare and Medicaid. In accordance with industry benchmarks, these baselines should be expressed as percentages of Medicare-allowed amounts.270 By tailoring reimbursement rate standards to these two areas, the mandates will present less of a shock to the private insurance industry than across-the-board behavioral reimbursement minimums otherwise might. Although nearly one in five Americans suffer from mental health conditions, only roughly one quarter of those Americans have SMI.271 Among individuals who actually seek treatment, the proportion is not much higher: slightly more than one third have SMI.272 People with SMI typically require more expensive treatment, but their lower numbers will help to limit the cost of reimbursement minimums to insurers.273

Due to integrated care’s crucial role in the efficient delivery of affordable behavioral health care, regulators should also apply reimbursement minimums to integrated care models.274 Most people who seek mental health care do not have SMI, so they typically require more modest treatments that suit integrated care models.275

270. MELEK ET AL., supra note 12, at 5 fig.5.
271. Mental Illness, supra note 10 (“In 2020, there were an estimated 52.9 million adults aged [eighteen] or older in the United States with [any mental illness]. This number represented 21.0% of all U.S. adults. . . . In 2020, . . . 14.2 million adults [had] SMI.”).
272. Id. (“In 2020, among the 52.9 million adults with [any mental illness], 24.3 million (46.2%) received mental health services in the past year. . . . In 2020, among the 14.2 million adults with SMI, 9.1 million (64.5%) received mental health treatment in the past year.”)
273. Claire de Oliveira, Joyce Cheng, Simone Vigod, Jürgen Rehm & Paul Kurdyak, Patients with High Mental Health Costs Incur over 30 Percent More Costs than Other High-Cost Patients, 35 HEALTH AFFS. 36, 40–41 (“In [a] study, which examined all Medicaid high-cost patients in Maryland, the authors found that serious mental illness (affective psychoses and schizophrenia) and dependence on drugs, alcohol, or both were among the most frequent diagnoses for all high-cost patients with hospitalizations.”); see also Mental Illness, supra note 10.
274. AM. PSYCHIATRIC ASS’N, THE COLLABORATIVE CARE MODEL FOR MENTAL HEALTH: IMPROVES OUTCOMES, REDUCES COSTS, https://www.psychiatry.org/File%20Library/Psychiatrists/Advocacy/Medicaid-Payment-Collaborative-Care-Model/CCM-for-MH-One-Pager.pdf [https://perma.cc/N73W-NBPQ] (“Better care coordination via integration of mental health and primary care has been shown to improve patient access and outcomes. Three decades of research and over 80 randomized controlled trials (RCT) have identified one model in particular—the Collaborative Care Model (CoCM)—as being effective and efficient in delivering integrated care. It is estimated that $26 [–] $48 billion could be saved annually through effective integration of mental health and other medical care.” (citations omitted)).
275. Mental Illness, supra note 10 (demonstrating that most people who seek treatment for mental illness have relatively moderate illnesses).
sustainability and success of these models hinge on ensuring adequate reimbursement.\textsuperscript{276}

Further, accounting for plan type and regional price differences will allow the flexibility necessary to sustain the regime.\textsuperscript{277} Federally established minimums, however, prevent states from effectively skirting the problem with vague qualitative standards.\textsuperscript{278} Because increasing the specificity of regulations will not cure patchwork enforcement, states should establish reimbursement task forces with unequivocal enforcement authority.\textsuperscript{279}

To ensure that reimbursement rate minimums produce the intended effect—behavioral health care providers’ participation in insurance networks—regulators should also cap providers’ and payers’ allowable out-of-network charges to insured patients for behavioral health care, even if those patients knowingly receive care from an out-of-network provider. These caps should complement tax incentives that spur providers to participate in insurance networks and accept Medicaid.\textsuperscript{280} If not addressed from all sides, the market dynamics that make foregoing network participation more profitable for providers will remain unchanged.\textsuperscript{281}

With this multi-sided framework, reimbursement minimums should increase behavioral health care providers’ participation in insurance

\textsuperscript{276} Making the Case: Medicaid Payment for the Collaborative Care Model, AM. PSYCHIATRIC ASS’N, https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid/medicaid-payment-and-collaborative-care-model [https://perma.cc/G4NK-93NJ] ("However, successfully expanding use of the [collaborative care] model depends on appropriate reimbursement for services related to care management and psychiatric consultation, and infrastructure support for staffing changes and implementation of data tracking tools.").


\textsuperscript{278} See supra note 65 (noting most states’ tendency to use “broad, subjective standards” for regulating network adequacy).

\textsuperscript{279} See supra note 142 ("[State regulators’] authority to enforce MHPAEA . . . may provide inherent authority to review provider reimbursement rates for NQTL compliance.").

\textsuperscript{280} See infra Part III.B.

\textsuperscript{281} See infra note 157 ("[M]any psychiatrists may have so much demand for their services that they do not need to accept insurance.").
Financial considerations seem to best explain psychiatrists’ general reluctance to accept insurance, and low reimbursement rates comprise a substantial part of those considerations. Without regulatory intervention, the combination of high demand for psychiatric services and ballooning provider shortages will ensure that these harmful market dynamics remain controlling for many years to come.

2. **Strengthen Existing Network Adequacy Regulations and Their Enforcement**

To date, most states have scarcely enforced their network adequacy standards, whether qualitative or quantitative. Without enforcement, regulators will have difficulty determining whether regulations can provide sufficient protection as they currently exist. To avoid needlessly overburdening insurers and increasing the cost of health care, regulators should first focus on taking a more active, outcome-based approach to enforcement. To enable regulators to conduct comprehensive network adequacy reviews, regulations should require more accurate provider directories and increased provider participation in the process of updating directories.

    a. **Take a More Active, Outcome-Based Approach to**

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282. See, e.g., Goodell, supra note 13, at 5 (“The study’s authors speculate that low reimbursement (especially for psychotherapy services relative to medication management) . . . may [in part] explain why many psychiatrists do not accept insurance.”).

283. See id.


285. Legal Action Ctr., supra note 110, at 17 (“[M]ost states do not engage in rigorous, ongoing monitoring or take meaningful enforcement actions.”).

286. See id.

287. See infra Part III.A.2.a.

288. See infra Part III.A.2.b.
Enforcement

Ultimately, network adequacy regulations aspire to achieve access to care. Rather than trying to concoct the perfect regulatory formula at the outset, which will inevitably vary from state to state, regulators should first focus on realizing the full potential of their existing network adequacy regulations by enforcing them properly and adjusting as necessary. If regulators do not enforce the regulations they promulgate, piling on more will have little effect.

A system that emphasizes patient outcomes—as opposed to rigidly and automatically penalizing insurers for violations of quantitative requirements—best equips regulators to pursue network adequacy in a way that achieves the desired results while minimizing the burden on insurers. Generally, insurers and regulators broadly agree that an effective enforcement scheme requires some degree of flexibility. An outcome-based approach asks the ultimate question: Can patients get the timely care they need? Of the quantitative metrics, wait times best answer this question because they illuminate “actual ability to receive timely care.” Conversely, geographic standards or provider ratios simply shed light on the number and distribution of providers. Accordingly, regulators should conduct wait-time audits by requiring insurers to report wait times for in-network behavioral health care

289. HALL & GINSBURG, supra note 58, at 14 (“Even with quantitative standards in place, the ultimate question is whether available network resources are adequate for a patient’s particular needs.”).
290. See WISHNER & MARKS, supra note 277, at 5 (“In 2014, the consumer representatives to the NAIC commissioned a survey of state departments of insurance (DOIs); [thirty-eight] states responded to the survey. The results showed that . . . state DOIs rarely took enforcement actions for violations of network adequacy requirements.”).
291. See HALL & GINSBURG, supra note 58, at 22 (“Looser regulatory reigns on network composition would give health plans more flexibility to adapt to market conditions and to adopt promising innovations in care delivery.”).
292. WISHNER & MARKS, supra note 277, at 6–7 (“Although quantitative criteria can help regulators evaluate provider networks more efficiently and establish clear standards to review for compliance, stakeholders agreed that regulators need some flexibility in applying those standards to specific situations, such as areas with significant provider workforce shortages or topographic/geographic barriers. A bright-line standard cannot resolve every case.”).
293. HALL & GINSBURG, supra note 58, at 23 (“If quantitative standards are adopted, consideration should be given to maximum wait times (rather than simply number and distribution of providers). Wait times can be useful to monitor actual ability to receive timely care, and to help resolve individual disputes.”).
294. See id.
services. Regulators should also investigate wait times independently through “secret shopper” surveys.

In states that employ appointment wait-time requirements, insurers should pay fines when they cannot affirmatively demonstrate that, despite best efforts, market conditions prevent their compliance. In states that do not use wait-time requirements, panels of independent behavioral health experts should evaluate the results of wait-time audits to determine whether plans have the capacity to meet their enrollees’ needs in a reasonable time. Moreover, independent medical experts (who already conduct external reviews of “medical necessity” determinations on a case-by-case basis) should evaluate individual appeals for denials of out-of-network behavioral health care claims. When these independent experts determine that patients had no choice but to go out of network—regardless if they did so knowingly—regulations should prohibit insurers from holding patients financially liable. To appease insurers, however, external review processes should require patients to seek prior authorization whenever their condition allows. Due to the burden that appeals place on providers and patients, state regulators should not use them as the primary means of monitoring compliance.

295. Id. at 20 (“[H]ealth plans could either be encouraged, or required, to report typical or average wait times[,] . . . giving consumers information to evaluate when they shop for insurance.”).
296. Id.; LEGAL ACTION CTR., supra note 110, at 11.
297. HALL & GINSBURG, supra note 58, at 23 (“[Quantitative] metrics should be subject to exceptions for innovations in care delivery (telemedicine, centers of excellence), or when market conditions do not reasonably allow full compliance, despite best efforts.”).
298. See, e.g., 45 C.F.R. § 156.230(a)(2) (2016) (requiring, similarly to the qualitative standards used by many states, that ACA Marketplace plans “assure that all [mental health and substance abuse] services will be accessible without unreasonable delay”).
299. HALL & GINSBURG, supra note 58, at 23 (“The existing external review process by independent medical experts that is used to resolve ‘medical necessity’ dispute[s] can also be used to determine when patients should be allowed to go out of network to meet their medical needs.”).
300. Id. (“Patients should be held financially harmless when a reviewer determines there are grounds to receive care out of network.”).
301. Id. (“To allow health plans to arrange for needed services at reasonable costs, patients should be required to pursue external review in a timely manner, prior to treatment if feasible.”).
302. VOLK ET AL., supra note 142, at 13 (“While [behavioral health] provider[s] . . . are able to get [denials of coverage] overturned through the appeals process, repeatedly having to deal with [denials of coverage] creates undue burden on providers and patients.”); LEGAL ACTION CTR., supra note 110, at 12 (“Although regulators often monitor network adequacy through consumer complaints, this enforcement tool places an undue burden on consumers to monitor compliance and likely reflects an under-representation of compliance issues.”).
Once regulators step up enforcement measures, they can make more informed determinations about the need to alter existing regulatory frameworks in their states. For example, large rural states may still find geographic standards necessary even with controlled wait times. In the direst cases of provider shortages, states should consider passing narrow AWP laws that apply only to behavioral health specialists.

b. Strengthen Provider Directory Accuracy Standards

To buttress network adequacy enforcement efforts and improve behavioral health patients’ ability to reliably locate in-network care, federal regulations should require state to adopt their own reasonable standards for behavioral health directories. As of June 2020, fewer than half of states had their own standards for directory accuracy. Federal regulations should also require states to conduct periodic audits of their provider directories and report the results to federal regulators to keep tabs on the efficacy of network adequacy requirements.

Further, state regulations should also require providers to either proactively alert insurers when their information changes or respond to insurers’ requests to validate or update information within a certain

303. See LEGAL ACTION CTR., supra note 110, at 17 (“[M]ost states do not engage in rigorous, ongoing monitoring or take meaningful enforcement actions.”); see also JACOBI & RAGONE, supra note 47, at 23 (“In general, carriers, providers, regulators, and advocates crave more guidance regarding analyzing and evaluating NQTLs, like reimbursement rates and criteria used in selecting providers for networks.”).

304. HALL & GINSBURG, supra note 58, at 10 (“Quantitative standards need to reflect widely different demographic and geographic realities. In sparse, frontier areas, there are far fewer providers to go around . . . ”).

305. Market conditions—namely drastic shortfalls in patient choice (the problem area most frequently cited by AWP laws proponents) and low reimbursement for behavioral health care services (negating the bargaining-power arguments cited by AWP opponents)—justify limited enactment of these laws in states where insurers struggle to provide robust networks due to provider shortages. See supra Part II.A.3.

306. Directory accuracy standards typically entail requiring insurers to update their provider directories at regular intervals to ensure that consumers have the most up-to-date information about which providers they can see without incurring out-of-network expenses. See supra Part II.A.5.

307. Busch & Kyanko, supra note 64, at 981 (“Approximately twenty states have requirements directly related to directory accuracy for private plans . . . ”).

308. Id. at 982 (“States should also consider employing additional monitoring tools, such as patient surveys, audits, and comparisons to external data sources.”).
The insurance industry spends enormous sums trying to track down provider information, and although insurers should bear the ultimate burden of ensuring the accuracy of their directories, health care providers are better positioned to facilitate the process; insurers’ obligation of tracking down every provider in an insurance network presents a much greater challenge than a single provider’s task of reporting its own information.

Reports suggest that some providers are not aware of the importance of updating their information, and because regulations often do not require providers to update their information regularly, insurers’ requests for updates or verification may fall toward the bottom of providers’ list of priorities. Thus, requiring providers’ compliance with insurer requests will both raise awareness and make directory accuracy a priority for providers. Likewise, regulators must begin to prioritize directory accuracy themselves because of its importance for network adequacy enforcement. To affect sustainable change, however, incentives for behavioral health care providers to join insurance networks must supplement strengthened regulatory structures.

309. See AM’S HEALTH INS. PLANS, PROVIDER DIRECTORY INITIATIVE KEY FINDINGS 6 (2017), https://www.ahip.org/resources/provider-directory-initiative-key-findings [https://perma.cc/F4VA-DCSB] (describing providers’ general lack of engagement with the processes ensuring directory accuracy and their tendency not to prioritize submitting responses to insurance companies’ requests to validate or update their information).

310. Morse, supra note 195 (“An estimated $2.1 billion is spent annually across the healthcare system chasing and maintaining provider data.”); see also Busch & Kyanko, supra note 64, at 981 (“[L]ack of provider engagement . . . has been noted as [a] possible cause[ ] of directory inaccuracies.”).

311. AM’S HEALTH INS. PLANS, supra note 309, at 6 (“While providers indicated that they were familiar with provider directories and were aware that directories are used to help consumers find clinicians who are in-network, . . . they . . . [ex]pressed a general lack of awareness regarding the need to proactively alert plans of changes to their information [and] [d]id not understand the purpose of, or need for, responding to plan requests to validate or update their information[,]”). Also, providers “[f]elt overwhelmed with responsibility and therefore prioritized activities that were required of them by regulation or to secure payment for the provider.” Id.

312. See id.

313. See Busch & Kyanko, supra note 64, at 981.

314. See supra Part III.B.
B. Incentivize Psychiatrists to Accept Insurance

To expand access to mental health care, state and federal legislators should adopt a two-step, increasingly generous, tax incentive structure. The first step should directly incentivize psychiatrists to accept private insurance. Psychiatrists will decline insurance for as long as it remains profitable to do so.315 Further, psychiatrists who accept insurance are more likely to form group practices and hire ancillary staff to handle administrative work and insurance billing, which creates jobs and increases psychiatrists’ face time with patients.316

Second, governments should provide more generous tax incentives for psychiatrists to accept Medicaid. Individuals with SMI present as both the group most in need of psychiatric services and the group least able to pay for them.317 Data reveals “significantly lower Medicaid acceptance rates among psychiatrists than physicians in other medical specialties.”318 Nonetheless, in 2014, Medicaid funds accounted for one quarter of the total spending on mental health services and 21% of total spending on substance use disorder services.319 The following year, an estimated 2.5 million Medicaid recipients still reported an unmet need for mental health treatment.320 These figures highlight the importance of Medicaid acceptance in the effort to expand access to mental health care.321 Tax incentives can only go so far, however,

315. See Pear, supra note 157.
316. See Bishop et al., supra note 164, at 180 (“Solo practices often can function with much less infrastructure than larger single-specialty or multispecialty group practices. As a result, they may have little incentive to hire staff to interact with insurance companies.”); see also Kane, supra note 165 (detailing the large number of hours psychiatrists spend on administrative tasks).
317. See Levinson et al., supra note 160, at 114 (“[P]revious research has shown that earnings and long-term work incapacity are both much more strongly related to serious mental illness than to less serious forms of mental illness.”).
318. HONBERG ET AL., supra note 11, at 3.
320. Id. at 6.
321. See id.
without a simultaneous increase in the supply of providers to bridge the gap.\textsuperscript{322}

C. Bridge the Gap Between Behavioral Health Care Providers and Patients

Governments should take three steps to reduce the supply-demand gap for behavioral health care providers. First, governments must bolster workforce recruitment in the field. To that end, the federal government should reallocate funding for student loan assistance, and state governments should expand scopes of practice.\textsuperscript{323} Second, educators should establish experiential programs designed to pique interest in behavioral health careers early in education.\textsuperscript{324} Third, governments should cultivate telehealth and integrated care models.\textsuperscript{325}

1. Bolster Workforce Recruitment in Behavioral Health Care

Alleviating the cost of entering psychiatry remains a key method of bridging the supply-demand gap for behavioral services.\textsuperscript{326} PSLF


\textsuperscript{324} See \textit{infra} Part III.C.2.


\textsuperscript{326} See Budd, \textit{supra} note 212. On average, public medical school costs students $250,222, and private medical schools cost $330,180. \textit{Id.} The average medical student borrows between $183,000 and $200,000 to cover these high costs. Compare Samer Cabbabe, \textit{Would You Encourage Your Child to Follow in Your Footsteps and Become a Physician?}, 114 MO. MED., Jan./Feb. 2017, at 4, 4 (“The average medical student graduates with $183,000 in debt . . . “), with Budd, \textit{supra} note 212 (indicating the median medical school debt was $200,000 in 2019). Because psychiatrists are medical doctors, their degrees fall in this price range. \textit{Cost vs Reward of a Psychiatry Education}, DOCTORLY.ORG, https://doctorly.org/cost-vs-reward-of-a-psychiatry-degree/ [https://perma.cc/N2MM-R5AW].
provides one route to financial assistance that can help people become doctors, and society should not aim to dissuade them. Some of the funds currently allotted to PSLF, however, may achieve similar ends elsewhere while also doing more to reduce disparities for behavioral health.

Imposing modest limits on forgiveness for lower-demand medical specialists’ school loans under PSLF would allow a reallocation of those funds to NHSC programs, which specifically target behavioral health. Exemptions or higher caps for other in-demand groups such as primary care physicians—projected to become the primary recipients of PSLF—would help abate concerns about the collateral damage of these limits. Because other groups with relatively less severe shortage projections increasingly plan to apply for PSLF, even modest, narrow caps could produce substantial yields. These limits would complement recent increases in federal expenditures for behavioral health training.

Moreover, the design of NHSC programs themselves should be altered to provide a more generous benefit for behavioral health specialists. Currently, NHSC appears to reimburse loans at blanket rates across all disciplines. Though it offers different types of LRPs,
which repay up to different amounts, NHSC could encourage more aspiring health care professionals to specialize in behavioral health by providing more generous terms for the discipline specifically. The disproportionate supply-demand gap in behavioral health care would justify NHSC in carving out this exception. To ensure that other high-demand, NHSC-eligible disciplines do not bear the brunt of more generous behavioral health repayments, funding for the repayments should come from the new limits on PSLF medical loan forgiveness.

Further, because the HRSA designates so much of the land area in the United States as an HPSA for mental health, mental health care providers can choose from a wider array of practice locations while still maintaining eligibility for NHSC programs. Recruitment should emphasize this aspect as a selling point for would-be medical students who might not otherwise consider a career in psychiatry or apply to NHSC programs because they lack a desire or ability to relocate to a rural area. NHSC’s selection processes, however, temper the allure of the eligible locations’ diversity because NHSC understandably prioritizes areas and populations with the most need.

334. See Health Professional Shortage Areas (HPSA) — Mental Health, supra note 230 (depicting widespread HPSAs for mental health).
In addition to using federal dollars to make school more affordable for psychiatrists, state governments should expand behavioral health scopes of practice (SOPs). SOPs “define which services a state or territory allows a licensed or certified professional to perform.” Areas for reasonable expansion exist with many SOPs. For example, SOPs only authorize telehealth services by psychiatrists in thirty-one states, psychologists in twenty-one states, social workers in twenty-one states, and fewer for all other behavioral health professionals. More states should expand authorization of telehealth services to more behavioral health disciplines, particularly considering the expansion of telehealth services during the COVID-19 pandemic. Further, twenty-two states require an associate’s degree or higher to become credentialed as an addiction counselor. Relaxing educational and credentialing requirements wherever feasible would reduce barriers to a field desperately in need of more workers and allow cheaper and easier career alternatives to expand services in rural areas and beyond. At the same time, however, states should take care to promote behavioral health education programs.

340. See id. at 9.
341. Id.
342. Lisa M. Koonin, Brooke Hoots, Clarisse A. Tsang, Zanie Leroy, Kevin Farris, Brandon Jolly, Peter Antall & Bridget McCabe et al., Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic—United States, January–March 2020, 69 MORBIDITY & MORTALITY WKL. REP. 1595, 1595 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6943a3-h.pdf [https://perma.cc/2PQM-XBQ6] (“During the first quarter of 2020, the number of telehealth visits increased by 50%, compared with the same period in 2019, with a 154% increase in visits noted in surveillance week 13 in 2020, compared with the same period in 2019. During January–March 2020, most encounters were from patients seeking care for conditions other than COVID-19.”).
345. See infra Part III.B.2.
2. Foster Interest in Behavioral Health Care Early in Education

In addition to strengthening programs that make medical school more affordable and expanding SOPs, governments should fund programs aimed at fostering early interest in science and medical careers. To date, many similar programs have yielded mixed results.\(^{346}\) Some studies, however, indicate that exposure to a field or an inspiring mentor can lead to a “defining moment” that inspires a young student’s career decisions.\(^{347}\) Researchers specifically suggest that psychiatry could benefit from increased early exposure.\(^{348}\)

To be sure, recruitment to the field of health care generally faces an uphill battle.\(^{349}\) Physicians constitute one of the unhappiest of professions: doctors commit suicide at higher rates than any other occupation, and in a survey of five thousand physicians, “nine out of ten . . . indicated an unwillingness to recommend health care as a profession.”\(^{350}\) The negative emotional impacts of the profession may be compounded by “compassion fatigue,” which can plague psychiatrists and other health care professionals alike.\(^{351}\)

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346. Lynne Holden, Bernice Rumala, Patricia Carson & Elliot Siegel, Promoting Careers in Health Care for Urban Youth: What Students, Parents and Educators Can Teach Us, 34 INFO. SERVS. & USE 355, 364 (2014); see also, e.g., Ryan Callihan, Grant Aims to Foster Science, Medical Careers, HERALD-TRIB. (June 28, 2017, 5:56 PM) ([Science Students Together Reaching Instructional Diversity (SSTRIDE)] aims to encourage students to pursue a career in STEM and ‘a possible future in health care.’ . . . More than half of the students who have gone through the SSTRIDE program have chosen majors in math, science[,] or health upon entering college.”).

347. Holden et al., supra note 346, at 359.

348. Paul J. Lambe, Thomas C. E. Gale, Tristan Price & Martin J. Roberts, Sociodemographic and Educational Characteristics of Doctors Applying for Psychiatry Training in the UK: Secondary Analysis of Data from the UK Medical Education Database Project, 43 BJPSYCH BULL. 264, 268 (2019) (“Perhaps . . . increased early exposure to teaching and practical experience of psychiatry for students and postgraduates may ameliorate the UK recruitment crisis.”).

349. See Press Release, Stuart Heiser, supra note 331, at 4 (describing the dire physician shortages projected by 2032). See generally Cabbabe, supra note 326 (describing the drawbacks of the medical industry and the rampant unhappiness among physicians).

350. Cabbabe, supra note 326, at 4 (“Doctors have the highest rate of suicide of any profession. Every year, between 300 and 400 physicians take their own lives, approximately one per day.”).

351. Joseph A. Bescarino, Richard E. Adams & Charles R. Figley, Secondary Trauma Issues for Psychiatrists, PSYCHIATRIC TIMES (Nov. 17, 2010), https://www.psychiatrictimes.com/view/secondary-trauma-issues-psychiatrists [https://perma.cc/HXA9-RXTD] (“Compassion fatigue has been clinically defined as the formal caregiver’s reduced capacity or interest in being empathic or ‘bearing the suffering of clients’ and is the behavioral and emotional state that results from knowing about a traumatizing event
The field of medicine, however, has its draws: high demand and projected workforce shortages translate to high salaries and promising job outlooks, which comprise perhaps the most salient lodestones.352 These characteristics apply equally to psychiatry.353 Further, psychiatry offers unique benefits that may attract some medical students: psychiatrists may enjoy a better work-life balance compared with other medical disciplines, and its family-friendliness has been seen as a selling point in recruiting medical students to the field.354 Recruitment should highlight these aspects. And although psychiatrists’ self-employment trends contribute to the inadequacy of insurance networks, the opportunity to be self-employed may attract some medical students.355

In addition to promoting psychiatry, pipeline programs should not neglect to promote less expensive career alternatives that still play an important role in bridging the supply-demand gap in behavioral health care.356 These educational programs would complement SOP expansions.357 To become a social worker, for example, most states minimally require a bachelor’s degree in social work (BSW), as experienced by another person.

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352. See Cost vs Reward of a Psychiatry Education, supra note 326; see also Physician Starting Salaries by Specialty: 2019 vs. 2018, supra note 222 (showing six-figure starting salaries for all types of physicians, and even for physician assistants and CRNAs).


354. Lambe et al., supra note 348, at 268, 269.

355. Cost vs Reward of a Psychiatry Education, supra note 326 (“The flexibility and autonomy that a self-employed psychiatrist enjoys is one of the most attractive rewards of starting a private practice. . . . Psychiatrist entrepreneurs can also set their own schedules, and choose to combine private practice work with hours at a hospital or a local facility, if they wish.”).

356. Compare Budd, supra note 212 (“The average four-year cost [of medical school] for public school students is $250,222. For private school students, the cost is $330,180.”), with Social Work Degrees: What You’ll Study, ALL PSYCH. SCHS., https://www.allpsychologyschools.com/social-work/degrees/ [https://perma.cc/39WH-SB4H] (“[T]he average annual cost[] to obtain a bachelor’s degree in social work (BSW) from] a four-year, public institution runs around $9,970 per year for in-state tuition.”).

357. See supra Part III.B.1.
compared with the approximately twelve years of school necessary to become a psychiatrist.\textsuperscript{358} To practice in a clinical setting, students need only a Master of Social Work (MSW) degree, which is priced modestly compared to the cost of medical school.\textsuperscript{359} The lower relative costs of these degrees may drive the higher rate of job growth for substance abuse, behavioral disorder, and mental disorder counselors, which outpaces even the explosive growth of the field of psychiatry.\textsuperscript{360}  

Finally, and perhaps most importantly, early exposure to the scale and prevalence of behavioral health problems in the United States will do more to diminish the stigma that surrounds them.\textsuperscript{361} Research has shown that people with a better understanding of mental health reject stigmatic views more frequently.\textsuperscript{362} Thus, by focusing on bolstering mental health education and awareness from an early age, the effects of harmful societal views about mental health conditions may be diminished.\textsuperscript{363}  

3. Remove Barriers to Behavioral Telehealth and Continue
Integrated Care Models

To maximize the potential of telehealth services in bridging provider-patient gaps, governments must address internet infrastructure and disparities in telehealth parity laws. First, public policy should aim to foster competition among internet service providers (ISPs) and expand the breadth and quality of services available to both urban and rural residents alike. Although some blame a relative lack of competition among ISPs on excessive governmental restrictions, others suggest that targeted regulations may actually increase competition. For example, one method for encouraging competition is through “local loop unbundling,” which involves requiring ISPs to lease parts of their infrastructure to competitors, allowing more companies to enter the market. In rural areas, granting temporary exemptions from these types of regulations might give ISPs additional incentive to expand their infrastructure there.

But private rural citizens cannot afford to rely entirely on market forces, so bringing broadband internet to rural areas would require direct federal investment. Since 2018, the Federal Communication Commission (FCC) has acknowledged the need for significant investment in rural broadband infrastructure.


365. Ryan Radia, Competitive Enter. Inst., Improving America’s Broadband Through Competition, Not Regulation, in ONPOINT 1 (2017), https://cei.org/sites/default/files/Ryan_Radia-_Improving_America_s_Broadband_through_Competition.pdf [https://perma.cc/8HUG-N9EH] (“A laundry list of acts and omissions by government officials at the federal, state, and local levels have discouraged companies from entering the broadband market. If lawmakers embraced a less restrictive, more open approach to private-sector deployment of wireline and wireless broadband infrastructure, many Americans might enjoy a more compelling array of choices among [ISPs].”); Dunn, supra note 364 (“[A] process known as ‘local loop unbundling’ . . . involves regulating ISPs to lease or open up the ‘last mile’ of their infrastructure to other ISPs, [which would] then sell internet service plans over the wires that are already in place. The immense barriers to entry for any would-be ISP would disappear.”).

366. Dunn, supra note 364.

367. See U.S. DEP’T OF AGRIC., A CASE FOR RURAL BROADBAND: INSIGHTS ON RURAL BROADBAND INFRASTRUCTURE AND NEXT GENERATION PRECISION AGRICULTURE TECHNOLOGIES 6 (2019) (“A recent Deloitte Consulting analysis estimates the United States requires between $130 and $150 billion over the next five to seven years, to adequately support rural coverage and 5G wireless densification.”).
Commission’s (FCC) Connect America Fund has conducted reverse auctions, which encourage ISPs to bid on the amount of subsidies they would need to bring internet services to a particular area.\(^3\) The FCC should continue these auctions. Although this method of allocating subsidies can effectively grant an ISP a short-term monopoly in a certain area, the exclusivity preserves ISPs’ incentives to invest.\(^4\) Once the infrastructure exists, regulators could phase in practices like local loop bundling to foster competition in rural areas.\(^5\)

Although the needed federal investment appears substantial, the funds supply an essential piece of the puzzle for the one in five Americans that live in a rural area, many of whom may otherwise be left behind.\(^6\) As dependence on the internet in modern life increases, so does recognition of the internet’s capabilities in the delivery of behavioral health care services.\(^7\) Beyond behavioral health care, governments should emphasize the financial benefits to ISPs and other

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\(^3\) Wallsten, supra note 247 (“Reverse auctions are likely to yield the best outcomes. In this case, the government would define the network services it believes everyone should have—hopefully based on a careful analysis of both supply and demand information—and geographic areas it wants covered, and ask companies to bid for how much money they would need in subsidies in order to build out in those areas.”); Rural Broadband Auctions, FED. COMM’NS COMM’N, https://www.fcc.gov/auctions/ruralbroadbandauctions [https://perma.cc/2GWV-PK7K] (Apr. 13, 2021) (“In 2018, the [FCC] conducted the first of these [reverse] auctions.”).

\(^4\) See Wallsten, supra note 247 (describing the auction process by which ISPs compete with one another for subsidies in a particular area).

\(^5\) Dunn, supra note 364 (describing how local loop bundling can foster competition).


\(^7\) Joseph Firth, John Torous, Brendon Stubbs, Josh A. Firth, Genevieve Z. Steiner, Lee Smith, Mario Alvarez-Jimenez & John Gleeson et al., The “Online Brain”: How the Internet May Be Changing Our Cognition, 18 World Psychiatry 119, 119 (2019) (“The [i]nternet is the most widespread and rapidly adopted technology in the history of humanity. In only decades, [i]nternet use has completely re-invented the ways in which we search for information, consume media and entertainment, and manage our social networks and relationships.”); see substance abuse & mental health servs. admin., supra note 209, at 6 (“Until recently, billing for telebehavioral health services was limited. However, this is changing as insurance carriers recognize that telehealth is able to provide evidence-based care in a cost-effective way.”).
industries to facilitate a more rapid expansion of rural internet infrastructure.\textsuperscript{373}

Moreover, states must permanently strengthen telehealth parity laws. Though only three of the forty-three states with telehealth commercial payer statutes fail to mandate coverage parity for in-person and telehealth services, only fourteen states mandate “true ‘payment parity.’”\textsuperscript{374} Low telehealth reimbursement, much like for behavioral health care services generally, disincentivizes providers from entering the telehealth market.\textsuperscript{375} Due to the long-term cost-effectiveness of telehealth, reimbursement parity benefits providers, payers, and patients alike.\textsuperscript{376}

Finally, health care providers should continue to employ integrated care models wherever possible to manage milder mental health conditions.\textsuperscript{377} Evidence firmly establishes that these models provide effective treatment and long-term savings.\textsuperscript{378} By collaborating on care, psychiatrists can improve health outcomes for both moderately and

\textsuperscript{373} See generally U.S. DEP’T OF AGRIC., supra note 367 (describing the numerous sectors of the agricultural and tech industries that stand to benefit greatly from better access to internet technologies). “Tech companies which stand to benefit from industry transformation continue to capitalize on [patterns of digital transformation] by developing new technologies, which according to one recent study, may help position themselves to capture a portion of an estimated $254 billion to $340 billion in global addressable digital agriculture market.” Id. at 17.

\textsuperscript{374} LACKTMAN ET AL., supra note 255.

\textsuperscript{375} See id. at 7 (“Without payment parity, a health plan could unilaterally decide to pay network providers for telehealth services at 50% of the reimbursement rate that health plan pays the provider for an identical in-person service. This is not a theoretical risk, and actually occurred when New York implemented its broad telehealth coverage law, which did not include any language regarding payment/reimbursement rates.”).

\textsuperscript{376} SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., supra note 209, at 6 (“[I]nsurance carriers [increasingly] recognize that telehealth is able to provide evidence-based care in a cost-effective way.”).

\textsuperscript{377} See UNÜTZER ET AL., supra note 234.

\textsuperscript{378} Wayne Katon, Jürgen Unützer, Kenneth Wells & Loretta Jones, Collaborative Depression Care: History, Evolution, and Ways to Enhance Dissemination and Sustainability, 32 GEN. HOSP. PSYCHIATRY 456, 457–58 (2010) (“In some studies of more complex depressed patients, . . . there was evidence of a high probability of savings in total medical costs associated with collaborative care.”); UNÜTZER ET AL., supra note 234, at 1 (“Implementation of evidence-based collaborative care in Medicaid . . . could substantially improve medical and mental health outcomes and functioning, as well as reduce health care costs.”); American Psychiatric Association, supra note 237, at 1:15–1:20 (“The Collaborative Care Model has a rich body of scientific evidence supporting its efficacy.”).
severely ill patients. Where possible, governments should encourage providers’ participation in these models.

CONCLUSION

The state of access to behavioral health care in the United States leaves much to be desired. Despite broad state and federal mandates of parity between behavioral care and other types of care, representation of behavioral health care providers in insurance networks lags far behind that of other types of providers. Regulations designed to cure inadequate networks have fallen short of their goals in behavioral health, largely due to a lack of adequate enforcement. Mounting nationwide provider shortages, particularly in rural areas, complicate efforts to expand access to behavioral health care services via insurance coverage.

Several reform strategies, however, can sharpen parity efforts and mitigate the danger of worsening provider shortages. Targeted expansions of loan repayment programs and scopes of practice can advance recruitment to the behavioral health workforce, and integrated care models can continue to promote its efficiency. The proliferation of the internet can bring about a new age of behavioral telehealth, which would bridge geographical divides. Educational programs can inspire the next generation of behavioral health specialists. Stronger requirements can improve the accuracy of provider directories and network adequacy reviews. Existing network adequacy regulations can realize their full potential through stronger, outcome-oriented enforcement measures. And finally, quantitative reimbursement standards and tax incentives can encourage behavioral health care

379. UNUTZER ET AL., supra note 234, at 5 (“Studies have also tested collaborative care interventions for different mental health conditions, including depression, anxiety disorders, and more serious conditions such as bipolar disorder and schizophrenia. Across this extensive literature, collaborative care has consistently demonstrated higher effectiveness than usual care.” (citations omitted)).


381. See generally CHEDI, supra note 71.
providers to participate in insurance networks, expanding access for all, but especially for individuals who need it most. Together, these changes can support the effort to prevent tragedies like the death of Kristi Bennett.