# TELEHEALTH IS HERE TO STAY: WHY MEDICAID SHOULD PERMANENTLY REQUIRE STATES TO OFFER MENTAL HEALTH SERVICES THROUGH TELEHEALTH

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## I. Introduction

A troublesome image: a global pandemic threatening the health of you and your loved ones, an over-crowded apartment with stir-crazy children, bills piling up, the peak of stressful family dynamics, job and income insecurity.[1] For many Americans, this scenario was reality during the COVID-19 pandemic.[2] Navigating everyday life during an ever-evolving public health emergency was difficult enough, but the addition of aggravating factors such as family problems or income instability elevated the risk of triggering new or preexisting mental health disorders.[3] At the onset of the COVID-19 pandemic in March

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[1] *See* Melissa Jenco, *Study: COVID-19 pandemic exacerbated hardships for low-income, minority families*, AAP NEWS (June 3, 2020), *archived at* https://perma.cc/5TPY-VJGF (finding that financial hardship and job loss are disproportionately impacting Black and Hispanic low-income families). Some of these material hardships include food insecurity, rent or mortgage default, shortage of money for bills, and inability to afford medical care. *Id.*

[2] *See* Abby Vesoulis, *Coronavirus May Disproportionately Hurt the Poor – And That's Bad for Everyone*, TIME (Mar. 11, 2020), *archived at* https://perma.cc/L3PG-RADL (postulating very early-on in the COVID-19 pandemic that low-income Americans would face particularly difficult issues, such as lack of child-care and inability to work from home). Limited access to healthcare and greater risk of transmission adds additional stress to low-income individuals and families. *Id.*

[3] *See* Margot Sanger-Katz, *Income Inequality: It's Also Bad for Your Health*, N.Y. TIMES (Mar. 30, 2015), *archived at* https://perma.cc/58LA-PEGH (explaining that stress may translate to mental health issues); Emily Bazar, *Tax-Funded Mental*

of 2020, up to 27% of parents reported worsening mental health.[4] Although the world has returned to some level of normalcy compared to the start of the pandemic, there is an increase in the number of people seeking mental health treatment.[5]

The COVID-19 pandemic required health services be moved online to slow transmission rates and keep patients safe.[6] With many primary care and specialty medical offices going remote so quickly, the small field of telehealth exploded overnight.[7] Although administering care for certain specialties, such as pain management or pregnancy, are not as conducive to online communication, mental

*Health Programs Not Always Easy To Find*, WASH. POST (Apr. 30, 2018), *archived at* https://perma.cc/38GT-LS2J (highlighting how rare tax-funded mental health programs such as the Mental Health Services Act are in the United States).

[4] *See* Stephen W. Patrick et al., *Well-being of Parents and Children During the COVID-19 Pandemic: A National Survey*, 146 PEDIATRICS 1, 3 (2020) (reporting that both parents and children reported worsening of mental health since the onset of the COVID-19 pandemic); Anna Gassman-Pines et al., *COVID-19 and Parent-Child Psychological Well-being*, 146 PEDIATRICS 1, 6 (2020) (hypothesizing that the COVID-19 pandemic had at least four mechanisms for worsening mental health of both parents and their children: loss of parent's jobs, loss of income, increased caregiving burden, and illness). The COVID-19 pandemic has disproportionately affected "vulnerable populations . . . including hourly workers . . . communities of color, who face high rates of infection and poor clinical outcomes; and families with young children, who face dual caregiver and/or breadwinner demands." *Id.* at 2.

[5] *See Mental Health and COVID-19*, MENTAL HEALTH AM. (Apr. 2022), *archived at* https://perma.cc/GL64-RFRH (highlighting the ever-growing mental health crisis during and after the pandemic).

[6] *See* Hudson Worthy, *THE NEW NORM IN HEALTHCARE: TELEHEALTH*, 15 CHARLESTOWN L. REV. 549, 550 (2021) (recalling how the United States federal and state governments were forced to adopt telehealth as the new norm after the onset of the COVID-19 pandemic); David A. Hoffman, *Increasing access to care: telehealth during COVID-19*, 7 J. L. & BIOSCIENCES 1, 1–2 (2020) (detailing the rapid increase and expansion of telehealth services because of the unique impacts of the COVID-19 public health emergency); Ellen B. Franciosi et al., *The Impact of Telehealth Implementation on Underserved Populations and No-Show Rates by Medical Specialty During the COVID-19 Pandemic*, 27 TELEMEDICINE & E-HEALTH 874, 874 (2021) (noting the "unique and sudden need" for the expansion of telehealth because of the COVID-19 pandemic).

[7] *See* Ankita Dosaj et al., *Rapid Implementation of Telehealth Services During the COVID-19 Pandemic*, 27 TELEMEDICINE & E-HEALTH 116, 116 (2021) (describing the explosion of telehealth services offered because of the COVID-19 pandemic); Hoffman, *supra* note 6, at 2 (detailing the rapid increase and expansion of telehealth services because of the unique impacts of the COVID-19 public health emergency).

health services appear very compatible with remote delivery.[8] While mental health services were readily available for many people through telehealth during the pandemic, low-income Americans and Medicaid recipients faced greater barriers in accessing mental health services due to a lack of resources.[9]

[8] *See* Carrie Macmillan, *Why Telehealth for Mental Health Care Is Working*, YALE MED. (Sept. 16, 2021), *archived at* https://perma.cc/V2PU-3LUH (asserting that telehealth has not only become common place, but may be preferable for mental health visits). *See also* Mylaine Breton et al., *Telehealth challenges during COVID-19 as reported by primary healthcare physicians in Quebec and Massachusetts*, BMC FAM. PRAC. (Sept. 26, 2021), *archived at* https://perma.cc/2LAS-N5UK (describing the positive and negative implications of telehealth applicability in primary care in both Canada and the U.S.). Many recent studies have left out the physician's perspective on the rapid implementation of telehealth during the COVID-19 pandemic. *Id.* Physicians in both the U.S. and Canada cited the potential for misdiagnosis without a physical exam or the presence of non-verbal cues. *Id.* The study also cited new musculoskeletal cases, pregnancy, pain cases, and some acute mental health cases, although the study was not specifically concerning long-term mental health telehealth. *Id.*

[9] *See* Brian Mastroianni, *Why It's Not Easy to Access Mental Health Care When You're Covered by Medicaid,* HEALTHLINE (Aug. 19, 2021), *archived at* https://perma.cc/WD7J-PEQ9 (describing the increased struggle to find mental health services for Medicaid recipients, who already struggled to access these services before the onset of the pandemic).

> Across the board, the past year and a half of the COVID-19 pandemic has negatively impacted people's mental health, creating a great need for support during a difficult, fraught time. Dovetailing with this great overarching demand for mental health support comes the bleak reality that some of the most vulnerable in our society might not always have the greatest access to mental health services to begin with. . . . Our nation's mental health resources are historically underfunded and strained to begin with. Add on top of that the realities of shortages in mental health care providers and barriers to accessing mental health care for many on Medicaid — especially people of color. The system is also buckling under the weight of deficiencies in infrastructure and support for its practitioners, and then there's the additional challenges that have been brought on by the COVID-19 pandemic.

*Id.* More and more Americans are seeking mental health services because of the drastic and traumatic shift "to the ways we work, socialize, and ensure the health and safety of ourselves and those around us." *Id.* Additionally, mental health services are chronically underfunded in the first place, and many providers do not accept Medicaid because of the low payment rates. *Id.* The strain on providers during the pandemic is also challenging and has led to a high burn out rate in the mental health field in general. *Id.*

Mental health services provided via telehealth and other remote servicing platforms must become more readily accessible to low-income Americans through Medicaid expansion to address the gaps in healthcare which were made glaringly evident by the pandemic.[10] In the past, Medicaid expansion has increased accessibility and quality outcomes for mental health, and the COVID-19 pandemic has taken telehealth from a burgeoning possibility to an exciting and timely new option for long-term delivery of mental health services.[11] Because mental health services traditionally do not require physical presence, mental health care via telehealth does not pose the same concerns that other health service categories entail, which allows for broader implementation.[12] Telehealth's cost-effective nature, combined with the ease of accessibility for most Americans, makes it an excellent option for permanent expansion of mental health services, particularly for low-income Americans receiving Medicaid benefits.[13]

[10] *See generally Analysis, infra* notes 129–35 (articulating the argument for the addition of mental health services through telehealth as federally-mandated coverage category through the Medicaid program).

[11] *See generally* Stacey McMorrow et al., *Medicaid Expansion from 1997 to 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Patients*, 54 HEALTH SERV. RSCH. 1347, 1348 (2018) (using analytic research to confirm that past Medicaid expansions have increased quality and access to mental health services). Studies have found that expanding Medicaid eligibility proffers many benefits including increased access to care and improved mental health outcomes for low-income parents. *Id.* at 1349. *See also* Macmillan, *supra* note 7 (finding that providers and patients alike are willing to expand telehealth mental health services beyond the pandemic); Hoffman, *supra* note 6, at 2 (highlighting the new possibilities for telehealth even post-pandemic); Dosaj et al., *supra* note 6 (explaining the benefits of expanding telehealth long-term, specifically in gynecology).

[12] *See* Macmillan, *supra* note 8 (citing several advantages to mental health services online such as gaining a glimpse into home-life, ability to choose between in-person and online, and convenience). *See also* Zara Abrams, *How well is telepsychology working?*, AM. PSYCH. ASS'N (July 1, 2020), *archived at* https://perma.cc/PX5E-KEWY (asserting the COVID-19 pandemic allowed for the expansion of "telepsychology"). After regulations on telehealth were temporarily suspended, individuals who never received mental health services were able to have access to them remotely for the first time. *Id.* In this way, telehealth can serve as a portal to mental health care access. *Id.*

[13] *See* Fabiola Carrión, *Will telehealth provide access or further inequities for communities of color?*, NAT'L HEALTH L. PROGRAM (Sept. 28, 2020), *archived at* https://perma.cc/BV8J-G5L8 (asserting that telehealth could be the most beneficial for Medicaid recipients, but they will need access to certain technologies to take advantage of the opportunity); Ana Maria Lopez et al., *Barriers and Facilitators to Telemedicine: Can You Hear Me Now?*, 41 AM. SOC'Y CLINICAL ONCOLOGY

## II. History

### A. Telehealth Usage Prior to COVID-19

Telehealth is defined as "any health-related service that utilizes electronic and communication technology to remotely deliver health or medical information."[14] Some experts and scholars will differentiate between the term's "telehealth" and "telemedicine", but for the purposes of this Note, any health service offered virtually will be referred to as "telehealth".[15] There are several telehealth delivery types, such as synchronous live video, asynchronous "store-and-forward" delivery through a secure email-like medium, and individual data collection through secure electronic submission called remote patient monitoring ("RPM").[16]

EDUC. BOOK, 25, 25 (2021) (arguing that expansions to telehealth for Medicaid recipients must continue post-pandemic).

[14] *See* Dosaj et al., *supra* note 7 (defining telehealth); Mei Wa Kwong, *TELEHEALTH AND PUBLIC PROGRAMS – EVOLUTION OF TELEHEALTH POLICY IN MEDICARE AND MEDICAID*, 15 J. HEALTH & BIOMEDICAL L. 7, 8 (2019) (differentiating between telehealth and telemedicine and noting the different modes of telehealth delivery); Lopez et al., *supra* note 13, at 25 (explaining the difference between telemedicine and telehealth). Telehealth is an "umbrella term that broadly houses all health services provided via telecommunication technologies . . ." *Id. Accord* Hoffman, *supra* note 6, at 2 (offering the definition of telehealth as "a broad set of services that includes telemedicine delivery of clinical care as well as nonclinical activities such as provider training, administrative meetings, and continuing medical education.").

[15] *See* Jeremy Sherer & Amy Joseph, *PHYSICIAN LAW EVOLVING TRENDS AND HOT TOPICS: TELEHEALTH*, 32 NO. 3 HEALTH L. 20, 20 (2020) (discussing the difference between "telehealth" and "telemedicine" and deciding that "telehealth" should be applied for a more expansive application of virtual healthcare); Hoffman, *supra* note 6, at 3 (including telemedicine within the umbrella of telehealth); Wa Kwong, *supra* note 14, at 8 (concluding that "telemedicine" will be encompassed within the term telehealth for the entirety of the law review article). *See* Abrams, *supra* note 12 (referring to mental health services provided virtually as "telepsychology" or "teletherapy"); HENRY A. SMITH & RONALD A. ALLISON, TELEMENTAL HEALTH: DELIVERING MENTAL HEALTH CARE AT A DISTANCE 9 (1998) (using the term "telemental" health to describe mental health services offered remotely).

[16] *See* Wa Kwong, *supra* note 14, at 8 (describing the three telehealth delivery modalities and what they entail); Hoffman, *supra* note 6, at 3 (concluding similarly that there are three modes of telehealth delivery and differentiating between the three); Jacob Hauschild, *SOCIAL DISTANCING WITH YOUR DOCTOR: THE*

Telehealth was originally developed to help rural communities receive medical care where services were not proximately available.[17] Due to the primitive nature of the technology, patients had to travel far distances to reach the few clinics with the technological capacity to connect the patient to a specialist.[18] It did not take long, however, for telehealth to further evolve into a new strategy that not only increased access to providers for rural communities, but also cut costs for medical care overall.[19] Politicians in the 1990s began to include

*PROMISE OF TELEMEDICINE IN MEDICARE AND MEDICAID, AND HOW TO PAY FOR IT*, 22 MINN. J. L. SCI. & TECH. 117, 122 (2021) (defining synchronous, asynchronous and RPM as three types of telehealth modalities).

[17] *See* Teresa Iafolla, *History of Telemedicine Infographic*, EVISIT (Feb. 25, 2016), *archived at* https://perma.cc/FE4U-FHZK (presenting the history of telehealth, starting in the early twentieth century through the 2015). NASA originally funded telemedicine projects in order to provide healthcare to astronauts. *Id.* "As these [NASA] projects started showing the capacity of telehealth to provide real solutions in the healthcare system, the U.S. government started applying the technology to areas with shortages of healthcare professionals and adequate medical care, especially in rural areas." *Id.*

[18] *See* Worthy, *supra* note 6, at 552 (identifying rural medicine as the initial target market for telehealth services); Lopez et al., *supra* note 13, at 25–26 (noting that early telemedicine practice required travel to a local clinic in order for a patient in a rural community to communicate with a specialist or subspecialist); Hauschild, *supra* note 16, at 120 (describing a doctor diagnosing a child with the croup over the phone in 1897). The military, NASA, and workers in other types of isolated working environments such as those studying in the Antarctic have also used remote healthcare services when none were available on site. *Id. See also* Scott A. Borgetti et al., *Telehealth: Exploring the Ethical Issues*, 19 DEPAUL J. HEALTH CARE L. 1, 1 (2017) (asserting that telehealth was first established for use by NASA and other remote or hard to reach personnel, specifically in times of war to provide medical care).

[19] *See* SMITH & ALLISON, *supra* note 15, at 4 (exemplifying the interest of government agencies in cutting costs and improving access through telehealth); Elizabeth Tobin-Tyler, *Health Justice in the Age of Alternative Facts and Tax Cuts: Value Based Care, Medicaid Reform and the Social Determinants of Health*, 12 ST. LOUIS U. J. OF HEALTH L. & POL'Y 1, 31–32 (2018) (expressing the U.S.'s interest in cutting healthcare costs). The U.S. spends more on healthcare than any other industrialized nation, and for this reason, politicians, insurance companies and hospitals are always searching for ways to cut costs. *Id.* at 32. *See also* Robert Pear, *Medicare Allows More Benefits for Chronically Ill, Aiming to Improve Care for Millions*, N.Y. TIMES (June 24, 2018), *archived at* https://perma.cc/P556-AR5W (explaining that 2018 Medicare expansion with telehealth for patients with chronic illness was meant to increase quality care while decreasing costs); Hoffman, *supra* note 6, at 2 (recalling how patients were encouraged to stay home, and telehealth provided the opportunity to still receive medical care and reduce transmission of COVID-19).

telehealth in their platform plans for healthcare cost reduction, believing it was a viable opportunity for a more affordable healthcare delivery method.[20] Despite technological advances and advances in healthcare delivery generally, there were still many questions regarding the reimbursement and regulation of remotely delivered health care services.[21]

Reimbursement is the process by which insurance companies either pay physicians directly after they are billed for services rendered, or patients pay out of pocket for services and file a claim with their insurance for the cost of care.[22] Health policy began addressing insurance issues through the Patient Protection and Affordable Care Act ("ACA") providing health insurance coverage to

[20] *See* Wa Kwong, *supra* note 14, at 7 (indicating that lawmakers in the 1990s were enthusiastic about expanding telehealth to lower costs but had concerns about implementation and regulation); SMITH & ALLISON, *supra* note 15 (highlighting the focus on telehealth as the future of healthcare to cut costs and improve outcomes); Borgetti et al., *supra* note 18, at 2 (noting a "reinvigoration of interest in telehealth" in the late 1990s and early 2000s as a possible means for cost-control).

[21] *See* Borgetti et al., *supra* note 18, at 2 (explaining that availability of internet connectivity and encryption software allowed for telehealth implementation to become a reality in the late 1990s and early 2000s); Wa Kwong, *supra* note 14, at 10 (imparting that technology in the 1990s was far from as advanced as personal devices are today which greatly limited the ability to expand telehealth services). It is important to remember that patient records were not computerized until the 2000s, although some literature suggested it become essential in the early 1990s. *Id.*

[22] *See HEALTHCARE 101: HOW HEALTHCARE REIMBURSEMENT WORKS?*, CONTINUUM (Jan. 26, 2022), *archived at* https://perma.cc/M9ZC-4HE8 (citing five steps to receive and retain healthcare reimbursement). The steps for retaining and receiving healthcare reimbursement are: (1) Documenting details necessary for payment; (2) Assigning medical codes; (3) Submitting the claim electronically; (4) Interpreting the payer's response; and (5) Preparing for post-payment audits. *Id.* Healthcare reimbursement is exceedingly convoluted for both patients and providers especially when compared to the straightforward nature of paying for services in other industries. *Id.* The healthcare reimbursement process is so burdensome, that some physicians refuse to accept payment through insurance, although most providers cannot afford to run their practices this way. *Id. See also* Joshua D. Gottlieb et al., *The Complexity of Billing and Paying for Physician Care*, 37 HEALTH AFFAIRS 619, 623 (2018) (finding that the complexity of billing for reimbursement has decreased since the passage of the Affordable Care Act). After running complex statistical analyses, Gottlieb, Shapiro, and Dunn found that "[d]espite the declines we found over time, the still-elevated level of billing complexity in Medicaid raises concern." *Id.* at 625.

many who were not previously covered.[23] This increased coverage naturally led to a higher demand for services, which unfortunately caused an unintended shortage in providers.[24]

### *B. Telehealth Implementation During COVID-19*

Concerns and fear surrounding COVID-19 transmission resulted in a sweeping and almost-instantaneous implementation of telehealth care with the goal of resembling the regular course of patient care.[25] To compensate for these changes, federal and state governments removed telehealth implementation barriers and allowed reimbursement for telehealth services.[26] Some of the pe previous barriers to telehealth included HIPAA guidelines and regulations concerning physician-licensing across state lines.[27] With the onset of

[23] *See* Nicole Rapfogel et al., *10 Ways the ACA Has Improved Health Care in the Past Decade*, CAP (Mar. 23, 2020), *archived at* https://perma.cc/4MN2-65ZS (citing the ACA's accomplishments such as drastically decreasing the number of Americans who are uninsured, as well as helping low-income individuals increase access to healthcare services).

[24] *See* Worthy, *supra* note 6, at 552–53 (describing the impact of the ACA on demand for providers and hypothesizing that telehealth could be the answer to the problem); Wa Kwong, *supra* note 14, at 17 (citing the implementation of the ACA as sparking increased state legislation surrounding telehealth, which also exacerbated the shortage of healthcare providers).

[25] *See* Hoffman, *supra* note 6, at 2 (recalling how patients were encouraged to stay home, and telehealth provided the opportunity to still receive medical care and reduce transmission of COVID-19); Lopez, et al., *supra* note 13, at 26–27 (explaining that medical providers quickly shifted to telemedicine for patient safety reasons); Abrams, *supra* note 12 (expressing that the shift towards telehealth completely changed the way normal mental health services were offered); Hauschild, *supra* note 16, at 117 (acknowledging that telemedicine did not fully take hold until the COVID-19 pandemic when patients could no longer see their physicians in person).

[26] *See* Abrams, *supra* note 12 (recognizing the shift of insurance companies, Medicare, Medicaid, and other state and regulatory agencies who temporarily changed rules to compensate for the new safety concerns COVID-19 posed); Hauschild, *supra* note 16, at 138–39 (citing 2020 guidance from the Center for Medicaid and Medicare Services ("CMS") which encouraged states to be flexible with reimbursement at the beginning of the pandemic).

[27] *See* Bill Siwicki, *The prominent issues telehealth must tackle when the pandemic passes*, HEALTHCARE IT NEWS (Aug. 25, 2021), *archived at* https://perma.cc/52QL-ZEZV (highlighting pre-pandemic telehealth regulations barriers that will have to be addressed post-pandemic). Dr. Mary Mulcare emphasized that HIPAA (Health Insurance Portability and Accountability Act of 1996) flexibility, reimbursement, and licensing will be key areas of heightened

the pandemic, however, previous concerns about privacy and licensing were momentarily lifted.[28] Although there were many issues with initial implementation and adaptation, physicians and other care providers eventually acclimated to the temporary norm.[29] To maintain continuity of care, government-funded health insurance such as Medicare and Medicaid also expanded and reimbursed for telehealth on a larger scale than was previously allowed.[30]

### *C. The Medicaid Program*

regulation, and hopes that new policy can implement telehealth as a resource in the future. *Id.*

[28] *See* Abrams, *supra* note 12 (noting that regulations from federal and state levels were relaxed to facilitate telehealth care at the onset of the COVID-19 pandemic); Sherer & Joseph, *supra* note 15 (exploring licensure and regulatory issues involved in telehealth implementation, as well as other topics such as informed consent, privacy, and social insurance reimbursement); Franciosi et al., *supra* note 6, at 874 (recalling the "sweeping regulatory reform" and legislative mandates following the onset of the COVID-19 pandemic to ensure broad coverage for telehealth services that had not been offered before).

[29] *See* Franciosi et al., *supra* note 6, at 874 (explaining how telehealth rapidly grew during the COVID-19 pandemic and caused quick transition to remote healthcare services); Lopez et al., *supra* note 13, at 25 (highlighting the interest and urgency in quick implementation of telehealth because of the COVID-19 pandemic, and how quickly providers acclimated to the new medium); Hoffman, *supra* note 6, at 2 (explaining that more recent technological advances such as broadband internet access, mobile devices, and electronic health records allowed for telehealth to be implemented quickly at the onset of the pandemic because it increased capability and cut down costs).

[30] *See* Seema Verma, *Early Impact of CMS Expansion of Medicare Telehealth During COVID-19*, HEALTHAFFAIRS (July 15, 2020), *archived at* https://perma.cc/7RC8-MR7L (describing the actions of the Centers for Medicare and Medicaid Services' at the beginning of the pandemic as "unprecedented" when it came to expanding telehealth for Medicare beneficiaries); *Trump Administration Drives Telehealth Services in Medicaid and Medicare*, CMS.GOV (Oct. 14, 2020), *archived at* https://perma.cc/9VW5-PHJ5 (announcing that CMS was "providing additional support to state Medicaid and Children's Health Insurance Program (CHIP) agencies in [an] effort to expand access to telehealth" due to the pandemic.).

The Medicaid and Medicare programs were signed into law in 1965 through Title XIX of the Social Security Act.[31] Medicaid is a complimentary program to the Medicare program, which offers healthcare coverage for those over sixty-five years old or those with an eligible disability.[32] There are a few key differences between Medicare and Medicaid; the most significant being that the Medicare program is funded and administered by the federal government, and the Medicaid program is jointly funded by the federal and state governments, but managed by the individual, sovereign states.[33] This

[31] *See* U.S. CTRS MEDICARE & MEDICAID SERV., *Program History*, MEDICAID.GOV (2021), *archived at* https://perma.cc/6C69-GJ4W [hereinafter *Medicaid Program History*] (identifying when the Medicaid Program was signed into law).

[32] *See* U.S. CTRS. MEDICARE & MEDICAID SERV., *Get Started with Medicare*, MEDICARE.GOV (2021), *archived at* https://perma.cc/L86K-RDLL [hereinafter *Get Started with Medicare*] (stating that Medicare is offered to individuals over the age of sixty-five, or earlier if the individual has a disability such as End-Stage Renal Disease (ESRD), or Lou Gehrig's disease (ALS)).

[33] *See* Robin Rudowitz et al., *10 Things to Know about Medicaid: Setting the Facts Straight*, KFF (Mar. 2019), *archived at* https://perma.cc/B2GL-TLYJ (outlining the key features and facts of the Medicaid program).

> Medicaid is financed jointly by the federal government and states. The federal government matches state Medicaid spending. The federal match rate varies by state based on a federal formula and ranges from a minimum of 50% to nearly 75% in the poorest state. Under the ACA, the federal match rate for adults newly eligible was 100% for 2014-2016, phasing down gradually to 90% in 2020 and thereafter (93% in 2019). The federal matching structure provides states with resources for coverage of their low-income residents and also permits state Medicaid programs to respond to demographic and economic shifts, changing coverage needs, technological innovations, public health emergencies such as the opioid addiction crisis, and disasters and other events beyond states' control. The guaranteed availability of federal Medicaid matching funds eases budgetary pressures on states during recessionary periods when enrollment rises. Federal matching rates do not automatically adjust to economic shifts but Congress has twice raised them temporarily during downturns to strengthen support for states.

*Id. See also* U.S. CTRS. MEDICARE & MEDICAID SERV., *Medicaid*, MEDICAID.GOV (2021), *archived at* https://perma.cc/Y4SH-WCTM [hereinafter *Medicaid Homepage*] (stating that the Medicaid program is jointly funded by states and the federal government); Wa Kwong, *supra* note 14, at 16 (naming the categories of people that Medicaid provides coverage to and specifies that both the states and federal government fund the Medicaid program).

means coverage in some states is more comprehensive than in others.[34] According to the Centers of Medicare & Medicaid Services ("CMS"), Medicaid "provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities."[35] As of September 2022, 83.9 million people receive coverage through the Medicaid program.[36]

### *D. Evolution of Medicaid and Telehealth Reimbursement*

In the 1990s, states began passing legislative reforms to create their own reimbursement schemes for Medicaid programs to include telehealth services.[37] California was one of the first states to pass Medicaid telehealth reimbursement legislation, but left much of the

[34] *See* Adam McCann, *States with the Most and Least Medicaid Coverage*, WALLETHUB (Mar. 15, 2021), *archived at* https://perma.cc/F76U-N9HK (comparing the best and worst state Medicaid programs in areas such as spending, quality, eligibility, and enrollment). The amount of money spent in each state does not necessarily correspond with the quality of the Medicaid program in the state, except in the case of Massachusetts, which spends the most, but also has the highest rank in quality. *Id.* Rhode Island is ranked second overall, with a relatively high score in eligibility, quality and spending. *Id.* Louisiana on the other hand has the best eligibility and enrollment, but scores much lower on quality, and ranks about in the middle of the pack on spending. *Id. See also* Nicol Turner Lee et al., *Removing regulatory barriers to telehealth before and after COVID-19*, BROOKINGS (May 2020), *archived at* https://perma.cc/7HTJ-K33S (noting that "no two states have the same regulations when it comes to coverage and payment."); Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KFF (Jan. 21, 2021), *archived at* https://perma.cc/VWC6-4Z27 (explaining that the COVID-19 pandemic will highlight the gaps in Medicaid coverage for the states that failed to expand the Medicaid program after the passage of the ACA). The twelve states that refused to adopt the Medicaid expansion plan that the ACA originally mandated will likely feel the impact of their decision since millions of Americans do not qualify for eligibility because their incomes are above the threshold allowed. *Id.* Additionally, most of the states that refused to adopt the Medicaid expansion are southern states with higher populations of poor uninsured adults. *Id.*

[35] *See Medicaid Homepage*, *supra* note 33 (identifying categories of people covered under the Medicaid Program).

[36] *See id.* (providing the statistic that 75.4 million people in the U.S. were covered by Medicaid according to the April 2021 Enrollment Report).

[37] *See* Wa Kwong, *supra* note 14, at 16 (recalling that state legislatures began drafting reimbursement policies for implementation of telehealth for Medicaid in the 1990s).

details of what would be covered under the program ambiguous.[38] By 2004, twenty-four states were reimbursing for telehealth services in some capacity, but there was still very little uniformity in the program's coverage and regulatory standards.[39] The remaining states still had tight regulation on telehealth services and would not reimburse for audio or text-only services, and sometimes required that patients receive telehealth care at an "originating site" outside of their home.[40]

One of the primary goals of the ACA was to expand the Medicaid program, and all but twelve states have complied with the expansion.[41] By broadening coverage to more people through a "regulated, competitive individual market," the Medicaid expansion more than halved the number of uninsured Americans by 2017.[42] The provider shortage and technological advancements after the passage of the ACA led to many states creating new Medicaid telehealth

[38] *See id.* at 16 (stating that in 1996, California's Medicaid program, Medi-Cal, was the first program to require some reimbursement for telehealth services for Medicaid recipients).

[39] *See id.* at 17 (citing a survey of state Medicaid directors which found that twenty-four states were reimbursing for some form of telehealth by 2004).

[40] *See* U.S. CTRS. MEDICARE & MEDICAID SERV., *Telehealth Services* (2020), *archived at* https://perma.cc/SE2M-TWSW (outlining updates to the telehealth policy for the Medicaid program during the COVID-19 pandemic). "An originating site is the location where a Medicare patient gets physician or practitioner medical services through a telecommunications system." *Id. See also* Hauschild, *supra* note 16, at 135–36 (explaining differences in regulations of Medicaid telehealth services in different states).

[41] *See Status of State Medicaid Expansion Decision: Interactive Map*, KFF (Oct. 8, 2021), *archived at* https://perma.cc/JQS9-4Y4L (stating that twelve states have yet to adopt the ACA Medicaid expansion); Hauschild, *supra* note 16, at 133 (explaining that the ACA allowed for increased access to Medicaid benefits, but twelve states still have not complied with the expansion). *See also* NFIB v. Sebelius, 567 U.S. 519, 522–23 (2012) (holding, among other things, that the federally mandated expansion of state Medicaid programs is both unconstitutional and a misuse of Congress' Spending Power). The ACA originally sought to expand the requirements for Medicaid entitlement in every state by raising the income requirement to 133% of the federal poverty line. *Id.* at 523. The Court found that threatening the withdrawal of all federal Medicaid funding if states chose not to comply was coercion. *Id.* at 585.

[42] *See* Turner Lee et al., *supra* note 34, at 3 (explaining how the ACA drastically changed health insurance coverage in the U.S. and was modeled after the Massachusetts state health-care plan).

legislation.[43] Traditionally, Medicaid programs have covered more telehealth services than Medicare, but there is still a lack of uniformity between state Medicaid programs' coverage of telehealth services.[44]

The COVID-19 pandemic and resulting public health emergency necessitated the deregulation and rapid implementation of telehealth as a primary form of physician-patient contact.[45] For Medicaid, this meant that each state was responsible for implementing their own changes, although CMS advised that states operate with "broad flexibility" for their reimbursement of telehealth services to "ensure that Medicaid services are delivered in a safe and economical manner."[46] This guidance led states to suspend licensing requirements and alter existing reimbursement policies, such as allowing for the "originating site" to be the patient's own home.[47] Other states adopted "parity clauses," which dictate that telehealth be reimbursed at the same rate as in-person health services.[48]

[43] *See* Wa Kwong, *supra* note 14, at 17 (detailing the reasons for Medicaid telehealth coverage expansion from 2014-2018).
[44] *See* Hauschild, *supra* note 16, at 133–34 (stating that Medicaid generally covers more telehealth services than Medicare, but that there is still little to no uniformity in regulations between states).
[45] *See supra* notes 25–30 (describing the almost instantaneous switch to telehealth at the onset of the COVID-19 pandemic).
[46] *See* Hauschild, *supra* note 16, at 138–139 (quoting CMS guidance published in 2020 to encourage states to drop telehealth regulations in light of the COVID-19 pandemic); *Trump Administration Releases COVID-19 Telehealth Toolkit to Accelerate State Use of Telehealth in Medicaid and CHIP*, CTRS. MEDICARE & MEDICAID SERV. (Apr. 23, 2020), *archived at* https://perma.cc/9M8X-WHDE (announcing that the Trump Administration released a toolkit to advise states on broadening telehealth coverage for Medicaid and Children's Health Insurance Programs ("CHIP") during the COVID-19 pandemic).
[47] *See* Hauschild, *supra* note 16, at 138–39 (describing changes that states made to their Medicaid telehealth reimbursement policies following guidance from CMS and the White House).
[48] *See id.* at 140 (explaining that "46 states expanded telehealth coverage during the 2020 public health emergency, and 38 states installed temporary payment party for some or all telemedicine services.").

### *E. Disparities in Health Outcomes, Including Mental Health, For Low-Income Individuals*

There are extreme disparities in healthcare access and outcomes for low-income individuals in the United States.[49] Many factors contribute to this issue and are known as social determinants of health; factors include: substandard housing, lack of access to quality nutrition, chronic stress, racism, and other environmental factors.[50] Internationally, the United States spends more on healthcare than any other industrialized nation, but has lower life expectancies and a higher level of chronic disease due to lack of access to basic necessities and opportunities.[51] Another leading cause of these issues is chronic stress,

[49] *See* Carrión, *supra* note 13 (asserting that the COVID-19 pandemic exacerbated existing inequities in healthcare access and outcomes). The deadly impact of COVID-19 on communities of color is due to "underlying conditions stemming from intergenerational trauma, work in high-risk jobs that are deemed essential" while still having less access to health care services. *Id. See also* Christina Severin & Michael Curry, *Telemedicine can address historic structural inequities*, BOS. GLOBE (Mar. 13, 2021), *archived at* https://perma.cc/5BHN-ANMR (acknowledging structural racism's effect on health care inequalities that were further highlighted by the COVID-19 pandemic); Abby Vesoulis, *supra* note 2 (explaining that the COVID-19 pandemic highlighted the deficits in the U.S.'s "fragile social safety net", and exposes the inequities in health coverage, access, and quality for low-income Americans); Sarah Ryan, *Bridging the Digital Divide: How COVID-19's Telemedicine Expansion May Exacerbate Health Disparities for Low-Income, Urban, Black Patients*, 30 ANN. HEALTH L. ADVANCE DIRECTIVE 295, 295 (2021) (defining social determinants of health and citing factors such as race, socioeconomic status, age, sexual identity, and ethnicity as possible factors which determine whether a person has good health outcomes).

[50] *See* Tobin-Tyler, *supra* note 19, at 31 (defining social determinants of health and identifying a non-exhaustive list of environmental factors and circumstances that lead to these inequities); Severin & Curry, *supra* note 49 (identifying social determinants of health as divers of health inequities such as higher rates of chronic conditions in Black and brown Americans); Carrión, *supra* note 13 (noting the impact of lack of access to health services for communities of color in the grim health outcomes from the COVID-19 pandemic); Vesoulis, *supra* note 2 (detailing the tight living quarters of low-income Americans as a health hazard during the COVID-19 pandemic); Ryan, *supra* note 49, at 295 (outlining the World Health Organization's definition of social determinants of health, and highlighting inequalities not only in access but also in quality of healthcare services).

[51] *See* David Mechanic, *Population Health: Challenges for Science and Society*, 85 MILLBANK Q. 533, 533 (2007) (comparing the effects of social and nonmedical factors that impact health, and more specifically, socioeconomic status (SES)). Although medicine has developed significantly over the past several decades, social class is increasingly recognized as a contributing factor to poorer health in

which can be exacerbated from exposure to various types of discrimination, eventually taking its toll on the body.[52] Additionally, lack of preventive care and only treating "downstream" effects of these social determinants of health contribute immensely to quality outcomes, as well as increased cost.[53] The effect of chronic stress on

lower social classes because of individuals' inability to protect themselves from adversities because of access to money, knowledge, beneficial social networks, influence, etc. *Id.* at 536–37. Disparate mortality rates in Black versus white populations is "of particular concern because they typically are large and relate to America's legacy of slavery, racism, and discrimination." *Id.* at 537. *See also* Jacob Bor et al., *Population health in an era of rising income inequality: USA, 1980–2015*, 389 THE LANCET 1475, 1475 (2017) (hypothesizing that income inequality is creating a "survival gap" for low-to-middle-income Americans which cannot be explained completely by individual risk factors like substance use, obesity, and smoking in low-income groups). Stagnated or decreased life expectancy in low-income populations can be attributed with "rising inequality including unequal access to technological innovations, increased geographical segregation by income, reduced economic mobility, mass incarceration, and increased exposure to the costs of medical care." *Id. See generally* Tobin-Tyler, *supra* note 19, at 32 (noting that the U.S. spends more on medical care but has worse outcomes due to chronic disease, environmental factors, and lack of access to care).

[52] *See* Tobin-Tyler, *supra* note 19, at 33 (asserting that the burden of chronic disease is more common and pervasive in racial and ethnic minorities who have low socioeconomic status because of a lack of control over their environments). The long-term, overlapping burden of low socioeconomic status coupled with lack of access to education decreases life expectancy and chronic heart disease and/or diabetes. *Id.* "All people experience stress, but chronic stress can do significant damage to the body. Stressful experiences such as trauma, violence, and the indignity of racial or gender discrimination take a toll on the body's organ systems and undermine its ability to regulate its stress response over time." *Id.* at 33–34.

[53] *See id.* at 32 (identifying chronic disease as a main driver of high healthcare costs in the U.S.). Chronic disease costs more to treat once it is in an advanced state; this is known as "downstream medical treatment" and many policymakers and public health officials have advocated for "upstream" preventative medical care to lessen the financial burden on the government and the individual patients. *Id.* at 34–35. *See also* Robert A. Hahn, *What is a social determinant of health? Back to basics*, 10 J. PUB. HEALTH RSCH. (2021) (describing the "upstream–downstream" metaphor used in the context of social determinants of health).

> There's a "Health Impact Pyramid" which emphasizes "[t]he focus [on] the interrelations among upstream and downstream determinants. Socioeconomic factors form the broad base of the pyramid, presumably indicating the breadth of influence on health outcomes. While downstream interventions, e.g., clinical encounters, address the health issues of smaller numbers of people

low-income individuals over time can result not only in physical disease, but lead to excruciating mental health problems and a propensity for substance use disorders.[54]

## III. Facts

As the COVID-19 pandemic continued, many Americans experienced new or worsening symptoms of mental health disorders stemming from stress, anxiety and depression.[55] The worsening of Americans' mental health requires more intensive and widely accessible treatment options become available.[56] Differing federal

> at a time and may be labor-intensive, upstream interventions often affect many people, i.e., whole populations."

*Id.*

[54] *See* Tobin-Tyler, *supra* note 19, at 34 (declaring that discrimination and other traumatic life experiences "are internalized over the life course and can induce chronic stress, [which] may alter multiple body systems, leading to higher rates of chronic disease, mental health problems, and substance abuse.").

[55] *See* Cecelia Smith-Schoenwalder, *Following CDC Guidance Reversal, Will Mask Mandates Make a Comeback?*, U.S. NEWS (July 29, 2021), *archived at* https://perma.cc/L27C-WR6G (highlighting the ever-changing nature of the COVID-19 pandemic regulations, even more than a year after the onset of the pandemic). The CDC's changing guidance on mask-mandates has caused outrage in many conservative states. *Id.* Vaccination and mask-wearing are two political "hot potato[es]", and the virulent delta strain, coupled with low vaccination rates increases concerns over the on-going pandemic. *Id. See also* Allen Smith, *Ongoing Pandemic Take Toll on Workers' Mental Health*, SHRM (Aug. 19, 2021), *archived at* https://perma.cc/7DY6-EEJ7 (reporting the COVID-19 pandemic continues to cause Americans in the workforce to feel stress, isolation, and anxiety). At-work stressors including concerns such as virus exposure at work, or job insecurity continue to impact the mental health of workers across the country. *Id.* More people are reporting having little to no interest or pleasure in work or other activities since the COVID-19 pandemic began. *Id. See also* Nirmita Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, KFF (Feb. 10, 2021), *archived at* https://perma.cc/Y7LW-PB8J (asserting that reports of worsening mental health have increased by up to thirty percent since the onset of the COVID-19 pandemic). Along with the increase in reports of mental unwellness, there have been coinciding reports of increased alcohol and substance use disorders as well. *Id.*

[56] *See* Panchal et al., *supra* note 55 (focusing reporting efforts on populations that are especially at risk of experiencing negative mental health outcomes or substance use disorder consequences since the onset of the pandemic). Populations that are more likely to be experiencing mental health and substance use disorders include,

coverage requirements, discrepancies in reimbursement, and general shortages of access to mental health care and substance use disorder treatment leave many unable to receive the care and therapy required.[57]

### *A. Americans Are More Mentally Ill Than Ever*

The COVID-19 pandemic was one of many factors driving the increase in mental health disorders, and has highlighted the need for greater access to mental health services.[58] The prevalence of mental health disorders has increased dramatically in the past few decades, although the reason for this rise is contested.[59] One explanation is that people are more likely now than in past generations to report mental instability, and physicians have developed better methods of detection

"young adults, people experiencing job loss, parents and children, communities of color, and *essential* workers." *Id.*

[57] *See id.* (reiterating that access to mental health services was also an issue even before the pandemic). Increases in unemployment may lead to an increase in the uninsured but could also increase enrollment in other federal option for insurance if they qualify for programs like Medicaid, COBRA, or the ACA marketplace. *Id.*

[58] *See* Alice G. Walton, *Why More Americans Suffer From Mental Disorders Than Anyone Else*, THE ATL. (Oct. 4, 2011), *archived at* https://perma.cc/U38E-P4ZW (noting that mental health disorders are pervasive in the United States, and that seeking more treatment doesn't mean the rates are decreasing). "Research shows that while we're seeking treatment more, rates have not dropped much, if at all, in recent years." *Id. See also* Robin S. Rosenberg, *Abnormal Is the New Normal*, SLATE (Apr. 12, 2013), *archived at* https://perma.cc/QU9V-5L5N (noting that up to half of Americans will be diagnosed with a mental illness in their lifetime). At the time the DSM-5 was released in 2013, "fewer than 6 percent of American adults will have a *severe* mental illness in a given year, according to a 2005 study, many more—more than a quarter each year— will have some diagnosable mental disorder." *Id.*

[59] *See* Amanda Macmillan, *Mental Illness Is on the Rise*, HEALTH (Apr. 18, 2017), *archived at* https://perma.cc/6FRJ-X8PM (citing lack of treatment options and provider shortages as reasons for increases in mental health disorders). Gaps in insurance coverage despite legislation passed in the last decade are still impacting Americans' access to adequate treatment options. *Id. See also* Rosenberg, *supra* note 58 (noting that Americans truly are getting "sicker", and it can't all be attributed to improvements in detection). Rates of anxiety in children, and neuroticism and narcissism in American adults have increased dramatically since the 1950s and 1960s. *Id. See also* Panchal et al., *supra* note 55 (explaining that the increased mental distress reported during the pandemic is adding to the already high rates of mental illness and substance use disorders that existed before the COVID-19 pandemic).

and diagnosis.[60] The now-mainstream phrase, "mental health is health" illustrates how Americans as a whole are increasingly amenable and accepting of mental health treatment as a viable healthcare service.[61] Mental health has been destigmatized tremendously, with up to 87% of American adults agreeing that mental health disorders are nothing to be ashamed of.[62] This newly found openness and acceptance of the existence and prevalence of mental health disorders could be due to a greater understanding and awareness of the importance of mental health care and has led to a higher rate of diagnoses as well as a higher likelihood to report.[63] Although there is a much brighter social outlook on mental health disorders, stigma still exists and rates of mental illness diagnoses continue to rise.[64]

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[60] *See* Rosenberg, *supra* note 58 (explaining that one reason for the increase in mental health diagnosis is the awareness and better detection). Mental health clinicians and physicians have advocated for better detection of mental illness for decades. *Id.* Now mental illnesses such as attention deficit hyperactivity disorder and depression can be detected at an earlier age to reduce the intensity and severity of symptoms. *Id.* While this increased awareness and detection is beneficial, it also raises rates of mental illness reporting. *Id.*

[61] *See* Emily Becker-Haimes et al., *It's time to pay for mental health care in America*, THE HILL (Oct. 29, 2021), *archived at* https://perma.cc/T3FJ-ZGP3 (asserting that the common phrase "mental health is health" highlights the trend toward people caring about mental health).

[62] *See Survey: Americans Becoming More Open About Mental Health,* AM. PSYCH. ASS'N (May 1, 2019), *archived at* https://perma.cc/V72R-TUVA [hereinafter *Becoming More Open*] (explaining that although there is still stigma involved with mental health, American adults have mostly positive outlooks on mental health). Up to 86% of American adults thought that those with mental health disorders could get better. *Id.* The CEO of the American Psychological Association, Arthur C. Evans, Jr., PhD, said the results of the survey were "encouraging, and a signal that the APA's and others' work over the years to promote mental health care is paying off." *Id.*

[63] *See* Rosenberg, *supra* note 58 (hypothesizing that if diagnosable mental illness is like being under a tent, we've continued to make the tent bigger by labeling what might have previously been considered somewhat normal). The US has certainly gotten better at diagnosing mental illness, but this is not the only driving factor for the increase in mental health disorders. *Id.*

[64] *See Becoming More Open*, *supra* note 62 (citing "[a] third of respondents (33%) agreed with the statement, 'people with mental health disorders scare me,' and 39% said they would view someone differently if they knew that person had a mental health disorder."). Further, the results of the survey showed that older adults were more accepting and felt less shame and stigma surrounding mental health disorders than younger adults. *Id. But see* Thomas A. Vance, *Addressing Mental Health in the Black Community*, COLUMBIA DEPT. PSYCH. (Feb. 8, 2019), *archived at* https://perma.cc/P53L-RBK2 (identifying the stigma associated with mental health

While social acceptance may be a factor, the influx of mental health disorders might also be due to an actual increase in American's overall mental un-wellness.[65] The COVID-19 pandemic, for instance, evidently exacerbated the prevalence of mental health disorders across the country, as stress and anxiety about the state of public health continued.[66] Of the same vein, the development of new technology and expansion of social media over the last two decades has also been

concerns as a roadblock to mental health treatment progress in the Black community); Ruth White, *Why Mental health Care is Stigmatized in Black Communities*, USC SCH. SOC. WORK (Feb. 12, 2019), *archived at* https://perma.cc/H6V2-B2TA (explaining the stigma attached to mental health in many Black communities and the higher instance of serious psychological distress in Black Americans due to issues compounded by systemic racism); Amy Morin, *Exploring the Mental Health Stigma in Black Communities*, VERYWELLMIND (Oct. 26, 2020), *archived at* https://perma.cc/U7BW-4JXU (discussing the reasons for stigma in communities like disbelief of the idea that mental illness is a health problem that requires treatment).

> Much of the research has found that the Black community has a high degree of stigma associated with mental illness. In the 1990s, a public opinion poll found that 63% of African Americans believed depression was a personal weakness and only 31% believed it was a health problem. Other studies have found that the Black community is more inclined to say that mental illness is associated with shame and embarrassment. Individuals and families in the Black community are also more likely to hide the illness. Individuals in the Black community may be more likely to believe that since they've survived so much adversity, they're strong—and no one has a right to tell them that there is something wrong with them (since they may view a mental health issue as weakness).

*Id.*

[65] *See* MADDY REINERT ET AL., THE STATE OF MENTAL HEALTH IN AMERICA 8 (2021) (reporting the findings of a national survey on current trends in mental health to promote mental health and advocate for prevention, early identification, and overall wellness). The Mental Health America report found that even before the COVID-19 pandemic, "19% of all adults experienced a mental illness", and this number has increased by 1.5 million people in the last year. *Id.* Mental illness in youths and youths of color is particularly high, as is suicidal ideation generally both in youth and adults. *Id.*

[66] *See* Ryan K. McBain, *How COVID-19 lessons can transform US mental health care*, THE HILL (June 2, 2021), *archived at* https://perma.cc/W7ZD-4FA2 (highlighting elevated rates of anxiety and depression that have persisted since the onset of the COVID-19 pandemic). "By one estimate, as many people experienced serious psychological distressed in just the first month of the pandemic as during the entire year before it began." *Id.*

posited as a culprit for the increased number of Americans seeking mental health treatment.[67]

Finally, in low-income families, rising mental illness might also be a result of generational trauma, systemic oppression, and the prevalence of drug or alcohol abuse disorders.[68] For example,

[67] *See* Helen Lee Bouygues, *Social Media Is a Public Health Crisis. Let's Treat It Like One*, U.S. NEWS (July 20, 2021), *archived at* https://perma.cc/MRF7-EW8P (finding that social media use is linked to negative mental health impacts, particularly amongst young people). "There's no doubt that, in the coming year, research will produce new insights into social media, its negative effects and possible policy solution." *Id. See also* Rhys Edmonds, *Anxiety, loneliness, and Fear of Missing Out: The impact of social media on young people's mental health,* CTR. MENTAL HEALTH, *archived at* https://perma.cc/RG6T-JLAX (claiming that it's clear that social media is intertwined deeply in many people's lives, leading to 'social media addiction' and worsening mental health). According to recent studies, "[t]he evidence suggests that social media use is strongly associated with anxiety, loneliness and depression." *Id. See also* Jacqueline Howard, *Facebook screens posts for suicide risk, and health experts have concerns,* CNN (Feb 12, 2019), *archived at* https://perma.cc/22FW-9DLU (discussing two public heath experts' demands that Facebook be more forthcoming with their suicide prevention efforts because they believed that the AI being used was insufficient); Jaron Schneider, *Mother Sues Instagram over Alleged Role in Daughter's Suicide*, PETAPIXEL (Jan 24, 2022), *archived at* https://perma.cc/2RHR-VUNP (detailing a lawsuit filed against Instagram and Snapchat by a mother who lost her daughter to suicide, which she claims was due to her serious addiction to the two platforms); Ian Russell, *Opinion: My daughter was driven to suicide by social media. It's time for Facebook to stop monetizing misery*, WASH. POST (Oct. 25, 2021), *archived at* https://perma.cc/BCE3-LG3U (telling the story of the author's daughter Molly's suicide at the age of fourteen due to Facebook and Instagram, and how the sites know of these devastating effects and essentially cash in on user's misery). Frances Haugen, a "Facebook whistleblower", testified in front of the U.S. Senate and detailed Facebook's knowledge that their algorithm was a health and safety risk. *Id*.

> Facebook's algorithms use engagement-based rankings to tailor content to each user, often showing them more and more extreme content based on what they engage with. For Molly, this meant an Instagram feed full of suicidal ideation and self-harm. And no one outside of Facebook knows how the algorithm is designed and what its effects are on its users. There are no means by which governments or independent regulators can review company policies and data to ensure its product isn't leading to harm or even death.

*Id*.

[68] *See* Sanger-Katz, *supra* note 3 (noting that it's well-known that living in a poor community can shorten expected life-span); Camille A. Nelson, *MENTAL HEALTH, THE LAW, & THE URBAN ENVIRONMENT: ARTICLE: FRONTLINES: POLICING AT THE NEXUS OF RACE AND MENTAL HEALTH,*

exposure to racism has been shown to dramatically affect an individual's mental health over time.[69] Additionally, stress stemming from of poor economic status, such as food instability, lack of adequate housing, job insecurity, and other social determinants of health can lead to new or worsening mental illness.[70] It is these types of environmental stressors that ultimately lead many Americans to abuse drugs and alcohol.[71] Recently, the opioid epidemic has been partially attributed to lack of treatment for long-term mental illness, and untreated substance use disorders also frequently impacts the mental health of the individual's family members and children.[72] Whether the rise in mental health disorders is due to lowered stigma, or whether

43 FORDHAM URB. L.J. 615, 615 (2016) [hereinafter MENTAL HEALTH & THE URBAN ENVIRONMENT] (discussing the intersection of social stressors like policing and the severe impact it has on mental health for people of color). "According to the Department of Health and Human Services' Office of Minority Health, Black people in the United States are significantly more likely than White people, indeed twenty ties more likely, to report having had serious psychological distress." *Id*. at 621.

[69] *See* Nelson, *supra* note 68, at 629 (quoting David H. Chae).

> [T]he impact of race is in racism--historically informed, perpetuated by institutions, and manifested in the set of assumptions, stereotypes, and biases that are attached to race, both externally and internally—positioning groups of people into relative positions of power and deprivation . . . [A] socio-psychobiological approach emphasizes how social inequalities generated by racism impact health, directly as well as by shaping psychological, behavioral, and biological vulnerability to disease.

*Id.*

[70] *See* Tobin-Tyler, *supra* note 19, at 53 (citing social determinants of health such as food insecurity, lack of adequate housing, and poor educations as drivers of worse health outcomes and higher instance of chronic disease). These environmental stressors can also lead to physical health problems as well. *Id.* at 33. "[R]esearch showing that adverse childhood experiences and 'toxic stress' in childhood are strongly correlated with poor adult health supports[.]" *Id.*

[71] *See* RAJITA SINHA, CHRONIC STRESS, DRUG USE, AND VULNERABILITY TO ADDICTION 1 (2008) (stating that chronic stress is a "well-known risk factor in the development of addiction and in addiction relapse vulnerability.").

[72] *See id.* at 2 (finding that there is strong evidence that early-childhood adversity is linked to risk of addiction). "Overwhelming evidence exists for an increased association between childhood sexual and physical abuse and victimization and increased drug use and abuse." *Id.* at 3.

Americans are generally less mentally well, there is an escalated demand for access to mental health services.[73]

### *B. Mental Health Services Are Working Through Telehealth*

Increased access to mental health services through expansion of telehealth has been lauded as one positive outcome of the COVID-19 pandemic.[74] For many people, finding and receiving mental health services can feel daunting.[75] Busy parents and working adults may find it difficult to travel to in-person appointments.[76] Not only are

[73] *See* McBain, *supra* note 66 (considering policy changes to increase accessibility for much needed mental health care through long-term implementation of telehealth).

[74] *See* Lyndon Haviland, *Make Medicare and Medicaid telehealth coverage permanent*, THE HILL (June 11, 2021), *archived at* https://perma.cc/GQX5-43Q9 (calling telehealth implementation during the pandemic a "silver lining" because it showed the human race's ability to persevere through tremendous adversity). "To be clear, there are no winners from COVID-19[,] [y]et if there were one to be crowned, the internet would likely take first prize." *Id.* Haviland goes on to say that moving telehealth "off the sidelines" revolutionized the delivery of health care. *Id. See also* Jane E. Brody, *A Pandemic Benefit: The Expansion of Telemedicine*, NY TIMES (May 11, 2020), *archived at* https://perma.cc/3D24-LLT9 (describing the transition to telehealth as a blessing because it "can result in faster diagnoses and treatments, increase the efficiency of care and reduce patient stress").

[75] *See* Haviland, *supra* note 74 (noting that mental and behavioral health treatment through telehealth made treatment more accessible for patients).

> Prior to the pandemic, a Cambridge University Press study found patients missed roughly [twenty] percent of their scheduled appointments for mental health treatment. During the pandemic, one Minnesota nonprofit health plan saw mental health visits skyrocket more than 2.000 percent. The demand is there, and telehealth has proven to be an extremely effective health care delivery tool.

*Id. See also* Taylor Bennett, *Why do people avoid mental health treatment? Here's a look at how judgement, doubt, pride, and misinformation come into play*, THRIVEWORKS (May 8, 2019), *archived at* https://perma.cc/KR7Q-NP4V (citing misinformation, shame, and uncertainty in the efficacy of mental health treatment as reasons why some Americans avoid seeking help).

[76] *See* Macmillan, *supra* note 8 (highlighting convenience as a huge benefit which has encouraged the use of mental health services over telehealth for those that would otherwise be too busy to keep appointments). "The convenience is unprecedented," said Dr. Paula Zimbrean, MD, "[p]atients can meet with us in their car on a lunch break, which is wonderful." *Id.* Paige Lembeck, PhD added telehealth is great for convenience, particularly transportation to and from appointments can be difficult "especially for families that [have] trouble with attendance." *Id.*

patients seemingly more comfortable with remote mental health visits, in some cases, they prefer remote healthcare to in-person visits overall.[77] Additionally, the utilization of virtual platforms to access mental health care has expanded in demographics that have traditionally shied away from seeking treatment, including men, people over sixty-five, and Medicaid patients.[78]

Mental health professionals and physicians have communicated that telehealth can be a viable alternative to in-person care for mental health treatment purposes.[79] In contrast, other

[77] *See* Robby Berman, *Many psychiatry patients prefer online therapy*, MED. NEWS TODAY (Jan. 20, 2021), *archived at* https://perma.cc/D72Q-RSX9 (finding in psychiatrist Dr. Jennifer Severe's study that out of 244 surveyed, roughly half reported that they would like to continue virtual mental health care after the pandemic is over); Jeff Wilser, *Teletherapy, Popular in the Pandemic, May Outlast It*, N.Y. TIMES (July 9, 2020), *archived at* https://perma.cc/JQH9-T8ZY (explaining that many patients prefer remote teletherapy because receiving treatment is less cumbersome, and allows more people to receive care, although there are some shortcomings);
Abrams, *supra* note 12 (explaining that delivering mental health care treatment through telehealth allows for patients to avoid the stigma of seeking psychological services and makes it more convenient).

[78] *See* Heather Landi, *Demand for virtual mental health care is soaring. Here are key trends on who is using it and why*, FIERCE HEALTHCARE (Oct. 23, 2020), *archived at* https://perma.cc/5H5M-BFDT (reporting increased use of mental health support through telehealth, and the positive feedback received from patients using telehealth services for mental health treatment). When comparing the use of mental telehealth services across providers like Doctor On Demand and Ginger, there was "growth…across the board" because of a growing comfort in seeking virtual care. *Id. See also* Lea Winerman, *Helping men to help themselves,* AM. PSYCH. ASS'N (June 2005), *archived at* https://perma.cc/846H-U2KY (explaining that society traditionally demands that men emulate a "tough, independent and unemotional" exterior that "isn't compatible with therapy"); Edith Cowan University, *Older people reluctant to ask for mental health support*, MED. EXPRESS (Oct. 29, 2019), *archived at* https://perma.cc/H6AE-YL8Q (citing an Australian research study which showed that older adults living with chronic illnesses are unlikely to use medical health services, although they have access to medicine because of skepticism, lack of encouragement, and believing they can't access the services); Mastroianni, *supra* note 9 (describing the barriers Medicaid recipients face when trying to access mental health services due to a lack of providers that accept Medicaid, a shortage of medical professionals overall, and that the pandemic has placed additional stress on the situation).

[79] *See* Abrams, *supra* note 12 (asserting that many psychiatrists and mental health professionals are enthusiastic about the expansion of telehealth for mental health treatment). "[R]esearch to date shows mental health care delivered remotely—also known as telepsychology or teletherapy—is effective[, and] [p]sychologists—along

providers reported looking forward to resuming in-person appointments and believed that telehealth should only be a short-term alternative; especially for certain treatment options, such as group therapy.[80] Despite conflicting support for the platform, patient preference and comfortability, decreased no-show rates, increased retention, and comparable efficacy have encouraged providers to continue with remote mental health appointments.[81] An additional benefit, better attendance for psychiatry appointments via telehealth, also positively correlates with compliance to a treatment plan and better mental health outcomes overall.[82]

### *C. Reimbursement of Audio Telehealth Versus Reimbursement of Video Telehealth*

with psychiatrists, social workers and others—have built a substantial literature base on telehealth interventions for a variety of problems and populations." *Id.*

[80] *See* Adianna Bermudez, *Telehealth is the best option for some but not all, mental health experts say*, CRONKITE NEWS (Nov. 9, 2020), *archived at* https://perma.cc/2XG9-E8UK (explaining that while some mental health services are effective through telehealth, there are benefits of in-person care that cannot be ignored). Certain therapeutic treatments, such as eye movement desensitization and reprocessing (EMDR) cannot be completed as effectively on a virtual platform. *Id.* Due to technical difficulties like bad internet connections, and struggling to navigate technology, support groups and free classes are less attended. *Id.* Meeting face-to-face for free classes or group sessions can forge greater connection between patients and can lead to better experiences. *Id. See also* Elisabeth Rosenthal, *Telemedicine Is a Tool. Not a Replacement for Your Doctor's Touch*, N.Y. TIMES (Apr. 29, 2021), *archived at* https://perma.cc/MAX9-75P9 (stating that virtual medicine works well for simple visits, but that there is a danger in telehealth becoming a "mainstay of our medical care").

[81] *See* Abrams, *supra* note 12 (quoting David Mohr, PhD, as saying "[w]hat we've seen is that telehealth is essentially just as effective as face-to-face psychotherapy—and retention rates are higher."). *See also Psychiatrists Use of Telepsychiatry During COVID-19 Public Health Emergency Survey Results*, AM. PSYCH. ASS'N (July 2021), *archived at* https://perma.cc/DP84-KZAH [hereinafter *APA Telepsychiatry Survey Results]* (finding that psychiatrists relied on telehealth for treating patients). Patient satisfaction, even for those who started their treatment through telehealth, reported 90% satisfaction with the care provided. *Id.* There was a significant decrease in no-show rates for appointments, which increases the likelihood that patients will continue their course of therapy. *Id.*

[82] *See APA Telepsychiatry Survey Results, supra* note 81 (explaining that improved access and better outcomes in general resulted in lowering of costs and preservation of community resources). "Research suggests that this results in better medication compliance, fewer presentations to the emergency departments, fewer patient admissions to inpatient unit, and fewer subsequent readmissions." *Id.*

Differences between audio-only telehealth and video telehealth have fostered debate about whether there will be future implementation delineating them from one another.[83] Video telehealth is characterized by the physician and patient's ability to see one another's physical form through a camera, while audio-only telehealth appointments can be implemented through an exclusively auditory medium, such as through a telephone call.[84] Most Americans can easily access broadband and high-speed Internet through their phones or other personal devices, which makes video telehealth visits fast, efficient and effective.[85] However, those living in rural areas, or those who cannot afford video-compliant devices, are left with audio phone calls as their primary means of connecting for a telehealth visit.[86]

[83] *See* Patrick J. Kennedy & John E. Sununu, *Why audio-only telehealth is a lifeline to healthcare*, THE HILL (Sept. 4, 2021), *archived at* https://perma.cc/EVZ6-GTLZ (reporting that Congress was debating whether to allow people to continue to receive telehealth care through audio-only interaction after the COVID-19 pandemic had subsided). The CARES act allowed for the secretary of Health and Human Services to waive certain requirements for telehealth during the pandemic, but now CMS is considering continuing audio-only telehealth for good. *Id. See also* Kat Jerich, *House reps seek to permanently safeguard audio-only telehealth coverage*, HEALTHCARE IT NEWS (May 25, 2021), *archived at* https://perma.cc/X7KB-RQEW (providing an update on HR 3447, "Permanency for Audio-Only Telehealth Act", which would allow Medicare coverage for audio-only telehealth services even after the COVID-19 pandemic is over). Flexibilities with regulations such as the allowance of audio-only telehealth visits would terminate at the end of the public health emergency, but lack of access to broadband would hurt many Medicare recipients if access to audio-only care could not continue. *Id.*

[84] *See Telemedicine During COVID-19: Video vs. Phone Visits and the Digital Divide*, NYU (Nov. 15, 2021), *archived at* https://perma.cc/N8ND-WEQ2 [hereinafter *Video vs. Phone Visits*] (discussing physician and patient descriptions of audio versus video telehealth appointments). Video telehealth visits are considered a "gold standard" alternative to in-person appointments because of the ability to see the patient. *Id.* However, the physicians recognized the importance of audio-only telehealth visits because it allowed for patients without the means to video-call to still receive care. *Id.* Additionally, "[t]elephone visits had unique benefits, including greater privacy, feasibility, and ease of use." *Id.*

[85] *See* Lee et al., *supra* note 34 (explaining that those who are affected by health disparities, including low-income populations and communities of color sometimes do not have access to smartphones, data plans, or Internet access).

[86] *See* Kennedy & Sununu, *supra* note 83 *(*explaining that factors such as race, income, and level of education can impact the likelihood that a person has broadband in their home). *See APA Telepsychiatry Survey Result*, *supra* note 81 (expressing concern over the use of audio-only telehealth visits for psychiatry

These inequities in access complicate the commonly-held notion that telehealth with video accessibility is preferable and more beneficial than audio-only telehealth visits.[87] Video telehealth supporters argue that even virtually, the ability to read body language and connect through eye contact is beneficial to both patient and provider, and is particularly important for medical appointments where there is a physical presentation of symptoms.[88] Fortunately, mental health services are more amenable to audio-only telehealth visits, and some patients actually prefer audio-only for mental health visits as it maintains some notion of privacy during times of vulnerability.[89] For these reasons, even the Medicare program announced it will permanently cover audio-only telehealth for mental health services,

patients). Some physicians are wary of audio-only telehealth encounters for high-risk patients, and providers are warned to use their discretion when assessing whether the patient's condition is compatible with audio-only care. *Id.*

[87] *See APA Telepsychiatry Survey Result, supra* note 81 (highlighting the need for audio-only telehealth services to ensure care for the disadvantaged populations who are left out because of the digital divide). Telehealth using video requires broadband and high-speed internet connection, which is not available to rural populations and indigenous people, who are more at risk of suicide and inadequate substance use disorder treatment access. *Id.*

[88] *See* Anne Carle, *The Benefits of Telehealth Video Conferencing*, HEALTH RECOVERY SOLS. (Jan. 30, 2022), *archived at* https://perma.cc/J5RD-Y9UB (recalling several instances of life-saving video calls with patients that saved lives). The author explains that on two different occasions, being able to see a patient through a video call saved the patient's life. *Id.* For monitoring high risk patients with chronic illnesses, video telehealth is especially crucial. *Id.* The ability to see physical presentations of illness such as red bumps on a patient's leg, or the patient's inability to breath can allow health workers to provide quality care from a remote setting. *Id.*

[89] *See* Quinn Hirsch et al., *Beyond Broadband: Equity, Access And The Benefits Of Audio-Only Telehealth*, HEALTHAFFAIRS (Sept. 20, 2021), *archived at* https://perma.cc/7HQ9-9YJA (explaining that allowing for audio-only telehealth increases equity and access for those without broadband, and allows for greater flexibility for providers and patients).

> As policy makers deliberate on the future of infrastructure and health care, they should consider how pressing needs are addressed in the immediate term. The telephone, a cheap and accessible tool, already exists to provide access to some forms of health care. Audio-only telehealth can and should serve as a bridge until two-way synchronous telehealth is affordable and accessible for all patients.

*Id.*

which may prompt Medicaid programs to follow suit and give recipients the option to utilize audio-only telehealth visits.[90]

### *D. Comparing Essential Health Benefits Under the ACA to Medicaid's Mandated Provision of Services*

The Affordable Care Act includes a provision requiring the coverage of certain health services in private health insurance plans.[91] This list of federally mandated coverage categories, called "Essential Health Benefits," include mental health as a benefit that Marketplace plans must cover.[92] So, for Americans who are able to afford private health insurance through their state's insurance Marketplace, mental health coverage must be provided.[93]

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[90] *See Telehealth practice in 2022: CMS expands coverage and access*, AM. PSYCH. ASS'N (Dec. 2, 2021), *archived at* https://perma.cc/4WXS-4P2W [hereinafter *Telehealth practice in 2022*] (confirming that CMS is officially adding mental health telehealth reimbursement to their 2022 Physician Fee schedule). The new rule requires infrequent in-person visits but should extend reimbursement of audio-only mental telehealth appointments even after the public health emergency. *Id.*

[91] *See CMS Proposes Audio-Only Communication for Telehealth to Treat Mental Health and Substance Use Disorders*, NAT'L. ASS'N FOR BEHAV. HEALTH (2021), *archived at* https://perma.cc/ZZY2-DM97 (outlining a proposed rule by CMS which would extend Medicare coverage to "audio-only communication technology for telehealth services to diagnose, evaluate, or treat established patients with mental health disorders and providing Medicare coverage for telemental health services for beneficiaries who are in their homes for appointments."); Jerich, *supra* note 83 (examining HR3447, or the "Permanency for Audio-Only Telehealth Act" which would continue Medicare reimbursement for audio-only telehealth visits even after the COVID-19 public health emergency regulations subside).

[92] *See* Julia Kagan, *ACA Health Insurance Marketplace*, INVESTOPEDIA (Mar. 15, 2022), *archived at* https://perma.cc/3RHR-Z99G (describing the Health Insurance Marketplace platform created by the ACA). The ACA created a Marketplace for purchasing health care at the federal level, and many states have developed their own Marketplaces to provide more options for citizens of each state. *Id. See also Essential Health Benefits*, HEALTHCARE.GOV (Nov. 21, 2021), *archived at* https://perma.cc/2CLX-MSMP (providing the ten categories of services that insurance plans are required to cover under the ACA). "These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more." *Id.*

[93] *See What Marketplace health insurance plans cover*, HEALTHCARE.GOV (Nov. 21, 2021), *archived at* https://perma.cc/UJF5-LJQT (offering "[m]ental health and substance use disorder services, including behavioral health treatment (this includes

Similarly, the federal government has categories of mandatory coverage for the Medicaid program.[94] Since Medicaid programs are run sovereignly by each state, the areas of coverage are inconsistent beyond a short list of federally-mandated coverage categories, including inpatient and outpatient hospital services, home health services, physician services, and more.[95] Surprisingly, the list of services does not completely line up with the ACA's mandatory marketplace requirements, and mental health is not a category of benefit coverage that is federally mandated for states to cover through their respective Medicaid programs.[96] Fortunately, most states do provide some form of mental health services coverage through their Medicaid programs.[97]

### *E. NFIB v. Sebelius And The Implications For Future Changes To The Medicaid Program*

counseling and psychotherapy)"). Prescription drugs are also a federally required coverage category for state Medicaid programs. *Id.*

[94] *See Mandatory & Optional Medicaid Benefits*, MEDICAID.GOV (Nov. 21, 2021), *archived at* https://perma.cc/DC9K-G5LS (listing fifteen mandatory coverage categories that state Medicaid programs must cover). Mental health is not a category expressly listed under Mandatory or Optional Medicaid benefits. *Id.* However, rural health clinic services and physician services are mandatory coverage categories, which could encompass mental health services. *Id. See also* James Maxwell et al., *Battling The Mental Health Crisis Among The Underserved Through State Medicaid Reform*, HEALTHAFFAIRS (Feb. 10, 2020), *archived at* https://perma.cc/6S8R-PK98 (arguing that Medicaid should be expanded to include mental health services because it would allow for low-income individuals mental health or substance use disorders to access treatment options).

[95] *See Mandatory & Optional Medicaid Benefits*, *supra* note 94 (providing mandatory categories of coverage for state Medicaid programs). *See also Health Insurance and Mental Health Services*, MENTALHEALTH.GOV (Mar. 18, 2020), *archived at* https://perma.cc/Y8XA-86Q5 (noting that all state Medicaid programs do offer some sort of mental health services and some also offer substance use disorder services to beneficiaries and Children's Health Insurance Program (CHIP) beneficiaries). It is up to the state to determine what services to give to adults on Medicaid or children through CHIP. *Id.*

[96] *See Mandatory & Optional Medicaid Benefits*, *supra* note 94 (requiring many categories of care, but not mental health services explicitly). *See Health Insurance and Mental Health Services*, *supra* note 95 (stating that for the adult Medicaid expansion populations, mental health and substance use disorder benefits must comply with requirements under MHPAEA).

[97] *See Health Insurance and Mental Health* Services, *supra* note 95 (explaining that state-offered mental health services "often include counseling, therapy, medication management, social work services, peer supports, and substance use disorder treatment.").

Despite the ACA's general success expanding medical insurance coverage for millions of Americans, it was one of the most politically divisive pieces of legislation to pass in the last several decades.[98] In response to its enactment, there were a litany of lawsuits filed protesting specific provisions, such as the individual mandate and Medicaid expansion.[99] One of these contested provisions was the individual mandate, which operated to penalize individuals who did not enroll in health insurance through Medicaid or the new state and federal healthcare marketplaces.[100] The role of the Medicaid expansion was to enroll individuals within 133% of the federal poverty line ("FPL") in every state to ensure continuity and consistency across the country.[101] The federal government offered to pay the majority of

[98] *See* Jonathan Oberlander, *The Ten Years' War: Politics, Partisanship, And The ACA*, 39 HEALTHAFFAIRS 471, 471 (2020) (reflecting on ACA a decade after its passage and declaring it a political triumph, but also as one of the most controversial and divisive pieces of legislation). "[T]he Affordable Care Act's 2010 enactment was the most important health reform achievement since Medicaid and Medicaid's passage. But ten years later, ACA politics are more tenuous than triumphal, and the ACA has not escaped the controversy that surrounded its enactment." *Id. See also* NFIB v. Sebelius, 567 U.S. 519, 522–89 (2012) (deciding the fate of the efficacy of key provisions of the ACA).

[99] *See Legal Cases and State Legislative Actions Related to the ACA*, NCLS (June 29, 2021), *archived at* https://perma.cc/6LMW-4L2P (articulating the magnitude of cases brought in opposition to the ACA as a whole or in part since its enactment). "Since 2010, various states, private entities and individuals have challenged parts or all of the ACA nearly 2,000 times in state and federal courts." *Id.* Six of these cases have reached the Supreme Court. *Id.*

[100] *See Summary of the Affordable Care Act*, KFF (Apr. 25, 2013), *archived at* https://perma.cc/895J-V9VH [hereinafter *Summary of the ACA*] (summarizing the ACA as it was originally enacted). The individual mandate "[r]equire[d] U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income." *Id. See also* Will Kenton, *Affordable Care Act (ACA)*, INVESTOPEDIA (Oct. 12, 2021), *archived at* https://perma.cc/CKY8-7VK5 (describing the ACA's provisions and specifying that Americans were required to enroll in health insurance for the individual mandate, but could use marketplace insurance, which had tax subsidies for low-income Americans).

[101] *See Summary of the ACA*, *supra* note 100 (detailing the Medicaid expansion). The ACA required states to expand Medicaid. *Id.*

> Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on

the cost of new enrollees through the year 2020.[102] However, if states failed to enroll, the federal government would withdraw funding contributions to that state's Medicaid program.[103] Many states fundamentally disagreed with the passage of the ACA, and states in the South were particularly hesitant to expand Medicaid programs because the South has a larger percentage of the population below 133% of the federal poverty line.[104] The states that refused to comply

> modified adjusted gross income. . . . [a]ll newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.

*Id. See also 2022 Federal Poverty Levels / Guidelines & How They Determine Medicaid Eligibility*, AM. COUNCIL AGING (Jan. 18, 2022), *archived at* https://perma.cc/645Y-4FQ9 (reporting the federal poverty line income amounts in the year 2022). For reference, 133% of the federal poverty line for a family of four in 2022 is $36,098. *Id.*

[102] *See Summary of the ACA*, *supra* note 100 (outlining federal funding for the Medicaid expansion through 2020).

> [S]tates will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates.

*Id.*

[103] *See* Christine Vestal, *Court Lets States Opt Out of Medicaid Expansion*, PEW (June 28, 2012), *archived at* https://perma.cc/L3BS-KPST (describing the ACA provision which allowed the federal government to revoke state Medicaid funding if it did not comply with the Medicaid expansion).

[104] *See* German Lopez, *The April 2014 Kaiser study on the South and Obamacare*, VOX (May 13, 2015), *archived at* https://perma.cc/T3PR-KANY (discussing the disparities in health insurance coverage in the south, partially due to the hold-out states who have refused to adopt the ACA's Medicaid expansion). Southern states that repudiated the Medicaid expansion have a higher percentage of citizens living in poverty than those living in the Northeast and Midwest. *Id.* These states would have benefitted the most from the Medicaid expansion because of this higher rate

with the expansion contended both provisions were unconstitutional, but the Medicaid expansion specifically was duly unlawful because it was a threat which could severely harm noncompliant states.[105] Even though the states had received partial funding for Medicaid and Medicare since opting into the program in the 1960s, the state budgets would not be able to sustain the programs alone.[106] The government argued that because the states had agreed to Medicaid program modification when they first signed on to participate in the program, the Medicaid expansion and its penalty were lawful.[107]

In *NFIB v. Sebelius*, the Supreme Court ultimately ruled the ACA constitutional with the exception of the Medicaid expansion, which the Court found was coercive to the states.[108] The

of poverty. *Id.* Southerners are also more likely to report poor health and inadequate access to affordable health care. *Id.* "The federal government covers most of the Medicaid expansion, but Southern states would have seen the largest cost increase compared to other US regions." *Id.*

[105] *See* KENNETH R. THOMAS, CONG. RSCH. SERV., RL42367, MEDICAID AND FEDERAL GRANT CONDITIONS AFTER NFIB V. SEBELIUS: CONSTITUTIONAL ISSUES & ANALYSIS 1–2 (2012) (analyzing the issues and implications for future changes to federally funded state programs post-*NFIB*). States primarily challenged the Medicaid expansion in *NFIB* because "the withdrawal of this aid would have a dramatic effect on the ability of the states to provide health care to their populations, and that the states had no choice but to comply with the Medicaid expansion provisions." *Id.* at 2.

[106] *See id.* at 7 (discussing the difference identified in *NFIB* between coercion and persuasion). While the federal government can impose a condition to federal grant money, it cannot coerce the states to act under the Tenth Amendment. *Id.* at 8. *See also* Jane Perkins, *Fact Sheet: The Supreme Court's ACA Decision and Its Implications for Medicaid*, NAT'L HEALTH L. PROGRAM (Apr. 15, 2013), *archived at* https://perma.cc/AWX7-722Q (summarizing the *NFIB* decision including a detailed overview of the issues in the case). The Court recognized previous amendments to the Medicaid Program in the 1980s and 1990s were fine because they only altered coverage for those populations originally identified in the Medicaid Act such as "the disabled, the blind, the elderly and needy families with dependent children." *Id.* In contrast, the Medicaid expansion did not create an option to opt-out, because the state would then lose about 10% of a state's overall budget. *Id.*

[107] *See* NFIB v. Sebelius, 567 U.S. 519, 582–83 (2012) (identifying the government's argument in support of the constitutionality of the Medicaid expansion).

[108] *See National Federation of Independent Business v. Sebelius (2012)*, LEG. INFO. INST. (Apr. 2, 2022), *archived at* https://perma.cc/K3SQ-VET6 (stating the Medicaid expansion was the only provision of the ACA found unconstitutional);

Court found that the Medicaid expansion was not a mere shift in degree, but rather a shift in kind for the Medicaid Program.[109] Chief Justice Roberts went as far as to say that withholding of Medicaid funds after decades of reliance by the states would be equivalent to "a gun to the head."[110] The basis of the decision was grounded in an analysis of previous Supreme Court cases, such as *South Dakota v. Dole*, articulating the difference between a condition and coercion with respect to federal grants and spending concerning the states.[111] The Court did not, however, address what would constitute coercive behavior versus a lawful use of the congressional Spending Power.[112]

*NFIB*, 567 U.S. at 580–81 (holding the Medicaid expansion an invalid use of Congress' Spending Power).

[109] *See* Perkins, *supra* note 106 (saying Chief Justice Roberts' opinion identifies the Medicaid expansion as a complete transformation of the Medicaid program because it would cover populations groups not originally included in the Medicaid program). The originally named categories for Medicaid coverage were "the disabled, the blind, the elderly, and needy families with dependent children." *Id.*

[110] *See NFIB*, 567 U.S. at 580 (describing the Medicaid expansion as more than a financial inducement or mild encouragement to participate).

> In this case, the financial "inducement" Congress has chosen is much more than "relatively mild encouragement"—it is a gun to the head. Section 1396c of the Medicaid Act provides that if a State's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that "further payments will not be made to the State." … State that opts out of the Affordable Care Act's expansion in health care coverage thus stands to lose not merely "a relatively small percentage" of its existing Medicaid funding, but *all* of it.

*Id.* at 581.

[111] *See id.* at 580 (discussing the difference between conditioning federal funding in order to induce a state to act, and coercing a state into compliance). *See also* South Dakota v. Dole, 483 U.S. 203, 206 (1987) (ruling that Congress can attach conditions to federal money grants). In *Dole* the Court found that Congress could impose a legal drinking age on states in exchange for federal money to build highways. *Id.* The Court found that raising the federal drinking age was "directly related to one of the main purposes for which highway funds were expended -- safe interstate travel." *Id.* at 208–09.

[112] *See* Thomas, *supra* note 105, at 16 (discussing the *NFIB* decisions shortcomings in regard to lack of clarity in the coercion analysis).

> Justice Roberts' failure to "draw a line" in *NFIB* would seem, on its face, to make future predictions regarding grants conditions problematic. Medicaid is one of the largest federal programs currently in existence, and consequently, withdrawal of all Medicaid funds for failure to meet the Medicaid expansion requirements under the ACA would be disruptive to state finances. It is not clear, however, how the court might compare the levels of

Fortunately for the sake of the ACA as a whole, the provision which included the penalty for failure to comply with Medicaid expansion was severed from the rest of the Act.[113]

Critics of the *NFIB* decision now question the future of federally funded state programs.[114] Justice Ginsburg's "Concurrence in Part," joined by Justice Sotomayor, argues the Medicaid expansion was in fact constitutional through Congress' Spending Power.[115] Because the Medicaid program was created with Congress' reserved "right to alter, amend, or repeal" provisions of the Medicaid Act, and the states agreed to these subsequent changes, Justice Ginsburg asserts the Medicaid program was never intended to be a permanently fixed program.[116] Her concurring opinion goes on to say, "Congress has amended the Medicaid program on more than 50 occasions, sometimes quite

> withdrawal threatened under the ACA from a variety of other large federal programs. It should be noted that, prior to the Court's decision in *NFIB*, various federal courts of appeals had considered and rejected coercion claims with respect to grants for state prisons, education, welfare, and transportation.

*Id.* at 17.

[113] *See NFIB*, 567 U.S. at 586 (allowing the Medicaid expansion provision to be severed from the rest of the ACA through a severability clause included in the legislation). The Court concluded that Congress would have wanted to preserve the remainder of the ACA despite the unconstitutionality of the Medicaid expansion. *Id.* at 587.

[114] *See* Lynn A. Baker, *The Spending Power After NFIB v. Sebelius*, 37 HARV. J. L. & PUB. POL'Y 71, 72 (2013) (discussing the implications of *NFIB v. Sebelius* on future decisions involving Congress' Spending Power).

> Simply put, the problem for modern spending power doctrine is this: How can the courts distinguish and invalidate those conditional offers of federal funds to the States that threaten to render meaningless the Tenth Amendment and its notion of a federal government of limited powers, while at the same time affording Congress a power to spend for the general welfare that is greater than its power to directly regulate the States?

*Id.*

[115] *See NFIB*, 567 U.S. at 589 (Ginsburg, J, concurring) (disagreeing with Chief Justice Robert's plurality that Congress' Spending Power does not extend to the application of the Medicaid expansion under the ACA).

[116] *See id.* at 625 (arguing the Medicaid program was created with an express understanding that Congress could change the program and states would be obligated to comply). Justice Ginsburg points out a key sticking point between her opinion and the plurality—that Justice Roberts sees the Medicaid expansion as a creation of a new program, while Justice Ginsburg considers it as an amendment to the original Medicaid Act. *Id.*

sizably" and "the Medicaid Act put States on notice that the program could be changed" from the time of enactment.[117] Further, Justice Ginsburg raised questions about the future of Spending Clause challenges, including the coercion inquiry, which she states will "involve political judgments that defy judicial calculation."[118]

## IV. Analysis

### *A. Telehealth Provides Accessible Mental Health Services When It Is Needed Most*

At a time when mental health issues like anxiety and depression are at an all-time high, access to mental health services has never been more crucial.[119] Although the panic of the pandemic seems to have subsided, and most doctor's appointments have been moved back in-

[117] *See id.* at 627–28 (identifying some of the amendments made to the Medicaid program over the decades since its enactment).

> [B]etween 1988 and 1990, Congress required participating States to include among their beneficiaries pregnant women with family incomes up to 133% of the federal poverty level, children up to age 6 at the same income levels, and children ages 6 to 18 with family incomes up to 100% of the poverty level. These amendments added millions to the Medicaid-eligible population.

*Id.* (internal citations omitted). *See also* Robert Pear, *Clinton to Expand Medicaid For Some of the Working Poor*, N.Y. TIMES (Aug. 4, 1998), *archived at* https://perma.cc/4322-95RL (detailing the administrative policies Clinton passed which offered Medicaid coverage to working poor populations who had not qualified previously). The Clinton Administration tried to facilitate sweeping healthcare reform, but this effort was largely a failure, with only a few changes to the Medicaid program. *Id.*

[118] *NFIB*, 567 U.S. at 643–44 (discussing the future of Spending Clause challenges and the amorphous new coercion inquiry formulated by the plurality opinion).

[119] *See* Reinert et al., *supra* note 64 (analyzing mental health trends in America). "The rate of adults experiencing suicidal ideation increased by 0.15% from 2016-2017 to 2017-2018[,]" and there has been a larger increase in the past year. *Id. See also* Maxwell et al., *supra* note 94 (explaining how the ACA helped expand mental health treatment access, but there are still issues that need to be addressed).

> Total deaths from suicide, alcohol, or drugs, what some call "deaths of despair," increased by 51 percent from 2005 to 2016 in the United States, and drug overdose deaths increased by 16 percent per year between 2014 and 2017. These statistics reflect the well-documented opioid crisis and what some experts have called a national "mental health crisis."

*Id.*

person, plenty of Americans would like to keep remote telehealth as an option for their care.[120] This preference largely relates to convenience: patients do not want to commute, parents do not want to find childcare, and time does not have to be wasted sitting in the waiting room.[121]

Mental health services offered through telehealth can address other issues patients have with aspects of in-person treatment as well; for example, for those who are embarrassed about receiving mental health treatment, telehealth provides a long-term solution by making visits discrete and private.[122] The ability to access mental health services remotely during the pandemic showed promise of reducing the number of appointment-no-shows, accommodated last-minute emergency appointments, and also kept the immunocompromised safe from risk of COVID-19 infection.[123] Of course, patients should still have the option to receive in-person care if they prefer, but providing

[120] *See* Berman, *supra* note 77 (outlining the change from in-person to online mental health services due to the pandemic, and why some patients may want to keep it that way). To avoid interrupting mental health care treatment, psychiatrists and other mental health specialists were forced to move to remote care to replace office visits. *Id.* "Roughly half of the people surveyed said that they hope to continue virtual mental healthcare even after the pandemic is over." *Id.*

[121] *See id.* (citing convenience as a prime justification for keeping mental health services remote after the pandemic). Psychiatrist Dr. Jennifer Severe of the University of Michigan in Ann Arbor (the lead author of the study discussed) said, "many of the type of obstacles that commonly prevent a person from getting to an in-person appointment — such as feeling debilitated, lacking transportation or child care, or having trouble getting time off from work — are unlikely to prevent showing up for a virtual appointment." *Id.*

[122] *See* Haviland, *supra* note 74 (noting the benefits of remote mental health services and the need to continue insurance coverage for these services because it encourages patients to attend treatment).

> Forcing patients to attend in-person mental or behavioral health care visits can actually reduce care-seeking behavior. Virtual visits can make it easier for patients to access the care they need. It can reduce the stigma often associated with treatment, and allow people to receive services in the comfort and privacy of their own home.

*Id. See also Video vs. Phone Visits*, *supra* note 84 (explaining that telehealth visits through the phone can feel more private).

[123] *See Video vs. Phone Visits*, *supra* note 84 (citing a reduced number of no-shows as a benefit of remote care). *See also* Brody, *supra* note 74 (stating that accessing treatment through a remote setting can be preferable for patients who do not want to be exposed to COVID-19).

both options allows the patient receives their preferred delivery to ensure a high-quality of care.[124]

### *B. Mental Health Telehealth Should Be Permanently Reimbursed at The Same Rates as In-Person Care*

Those who cannot afford childcare or cannot travel to appointments should not be disqualified from receiving mental health treatment, and those who prefer to receive mental health treatment remotely should be entitled to choose in-person or remote appointments.[125] To empower the patient's right to choose, providers also must be compensated at the same rates, regardless of the mode of delivery.[126] If providers are not reimbursed at identical rates, they are

[124] *See* Turner Lee et al., *supra* note 34, at 9 (hypothesizing that a combination of in-person and remote treatment services could offer greater access to quality care). "Telehealth services supplementing in-person care can provide more frequent access to care than either via telehealth or in-person visits." *Id.*

[125] *See* Macmillan, *supra* note 8 (outlining why telehealth for mental health services is working, and that patients should be given a choice whether they want to be in-person or online). Some reasons to return to in-person care include the feeling of being in the room with someone, the inability to see micro-expressions or body language online, and the ability to really connect with a therapist. *Id.*

[126] *See* Hauschild, *supra* note 16, at 118–19 (citing the disparities in reimbursement as a reason telehealth services have not taken off in the past, and the reason why some are still wary of telehealth after the onset of the COVID-19 pandemic).

> [The] increased utilization of telemedicine was only possible because of changes to how providers were compensated for care delivered during this time. The United States predominantly uses a fee-for-service reimbursement system, wherein health care providers only deliver care that is pre-negotiated and billable to an insurer, which guarantees the provider payment for care given. Generally, providers fear that in the delivery of telemedicine, significant amounts of virtual care gets lost, not fitting within any specific "code" that can be billed to the payer. Therefore, practitioners who utilize telemedicine risk doing so at the cost of lost revenue whenever that care doesn't fit within a reimbursement code, despite the improved health care outcomes telemedicine offers for patients like Elroy. Because of the importance of remote care during the 2020 pandemic, many states and the federal government accommodated important changes to these codes--waiving existing restrictions and even offering grants to help health systems transition to new forms of care delivery. However, these changes are temporary, and coverage gaps will likely

likely to be deterred from offering remote services, which will effectively put an end to remote care.[127] The Medicare program, finding benefits of both platforms, has permanently added audio-only mental telehealth visits as a covered category of offered services, which hopefully will encourage private insurance and the Medicaid program to follow suit.[128]

### *C. Mental Health Telehealth Should Be A Federally Mandated Category For State Medicaid Coverage*

Mental health services through telehealth should become a mandated coverage category for state Medicaid programs.[129] Although states have primary control over their respective Medicaid programs and what services are provided, there are several federally-mandated categories of obligatory services.[130] Currently, mental health care services are not explicitly required, however, almost all

> reemerge once the threat of COVID-19 lessens and telemedicine reimbursement restrictions are put back in place.

*Id.*

[127] *See id.* (identifying reimbursement to providers as a factor in the increased utilization of remote care).

[128] *See Telehealth practice in 2022*, *supra* note 90 (announcing the addition of mental health telehealth as a permanent coverage for the Medicare program). This Medicare expansion included the reimbursement of audio-only mental health treatment which was previously excluded because of fear of overutilization. *Id.*

[129] *See* Haviland, *supra* note 74 (calling for the permanent expansion of the Medicare and Medicaid programs to include coverage for telehealth, specifically for mental health treatment). "Continuing Medicare and Medicaid coverage for telehealth visits is smart policy. It just makes good common sense. Let's make it permanent and improve the health and wellbeing of all Americans." *Id. See also* Maxwell et al., *supra* note 94 (discussing the disparities in mental health access for those with Medicaid and how expansions to the Medicaid program could provide coverage for millions of Americans who suffer with mental illness and substance use disorders). Offering more comprehensive mental health services through Medicaid could positively impact the behavioral issues of many low-income Americans. *Id.*

[130] *See* Wa Kwong, *supra* note 14, at 21 (discussing the history of Medicare and Medicaid expansion concerning telehealth). Medicare and Medicaid expansion often influence private insurance policies and one another. *Id.* In the 1990s, the Medicare program began passing legislation to reimburse for telehealth services. *Id.* at 10. Shortly thereafter, states like California and Oklahoma began to expand their state Medicaid programs to include reimbursement for telehealth services. *Id.* at 16–17.

state Medicaid programs include some coverage.[131] Since there is already a precedent for the federal government mandating that certain health services be covered by state Medicaid programs, a federally-mandated addition of mental health telehealth would ensure that all states, regardless of their individual policies, cover some form of much-needed mental health services for recipients.[132]

The Medicaid program is designed to help those who cannot afford health insurance due to low socioeconomic status.[133] Many individuals qualifying for Medicaid are members of minority communities that are traditionally underserved and face exacerbated levels of mental health concerns.[134] Allowing Medicaid recipients broader access to services means mental health treatment will extend to communities which historically have had limited access and greater need.[135]

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[131] *See Essential Health Benefits*, *supra* note 92 (providing the ten categories of services that insurance plans are required to cover under the ACA). "These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more." *Id. See also Mandatory & Optional Medicaid Benefits*, *supra* note 94 (listing fifteen mandatory coverage categories that state Medicaid programs must cover). *But see* Mastroianni, *supra* note 9 (explaining that due to the COVID-19 pandemic, Medicaid enrollment is at an all-time high, and the system does not provide quality mental health services generally speaking). People enrolled in Medicaid face even higher barriers to mental health services than those with private insurance because it is underfunded. *Id.*

[132] *See* Hauschild, *supra* note 16, at 133–34 (identifying Medicaid as a state-run public program, differentiating it from the Medicare program which is run by CMS); Mastroianni, *supra* note 9 (citing the inadequacy of state Medicaid programs that have refused the ACA Medicaid expansion and the effect on access to mental health services). Medicaid enrollment has significantly increased since the onset of the pandemic, and policy makers need to make changes to support those who need access to mental health services. *Id.*

[133] *See* Wa Kwong, *supra* note 14, at 16 (describing the Medicaid program). "Medicaid is administered by the states and jointly funded with the federal government. It provides health coverage to eligible low-income adults, children, pregnant women, the elderly and people with disabilities. As of October 2018, over 66 million have Medicaid coverage." *Id.*

[134] *See* Hauschild, *supra* note 16, at 152 (noting that those enrolled in public programs like Medicaid have the most to gain from telehealth implementation because they traditionally have the worst coverage and health outcomes). Coming from a low-income background can impact health literacy, which can contribute to poor health outcomes because low-income patients cannot successfully navigate the healthcare system. *Id.* at 153.

[135] *See* Turner Lee et al., *supra* note 34, at 1 (finding that the Medicaid expansion of the ACA would have increased access to communities who need it most). Any

### *D. NFIB v. Sebelius And National Medicaid Modification*

Since the *NFIB* decision, where the Court found Medicaid expansion unconstitutional, the constitutionality of federal modifications to the Medicaid program, or any well-established federal-state funded program, is unclear. The plurality opinion found the ACA's provision mandating expansion was too coercive, as it threatened the withdrawal of all federal Medicaid funding to states failing to comply with the expansion.[136] This decision took away federal power to enforce Medicaid expansion, and the effects of failing to adopt Medicaid expansion are apparent in noncompliant states.[137] Unfortunately, the twelve states that elected to not expand their Medicaid programs experience extremely high poverty rates, meaning even those well below the federal poverty line do not qualify for

kind of Medicaid reform, including the ACA expands access to "people of color, [whose] health disparities have been extensively documented, largely due to pre-existing medical or chronic conditions, including those affecting the more aged in this population. Rural communities are also impacted by the lack of proximity to local medical facilities and providers." *Id.*

[136] *See* NFIB v. Sebelius, 567 U.S. 519, 581 (2012) (describing previous exercises of the Congressional Spending Power as a "relatively mild encouragement", and the ACA Medicaid expansion mandate as "a gun to the head"). "A State that opts out of the Affordable Care Act's expansion in healthcare coverage thus stands to lose not merely 'a relatively small percentage' of its existing Medicaid funding, but *all* of it." *Id.*

[137] *See* Garfield et al., *supra* note 34 (citing issues in the states that have refused to expand their Medicaid programs as outlined in the ACA). In the states that have refused to apply the Medicaid expansion, there is a class of individuals who are not entitled to Medicaid, but also cannot afford Marketplace insurance; this is known as the "Medicaid Coverage Gap." *Id.*

> Most people in the coverage gap live in the South, leading state decisions about Medicaid expansion to exacerbate geographic disparities in health coverage. In addition, because several states that have not expanded Medicaid have large populations of people of color, state decisions not to expand their programs disproportionately affect people of color, particularly Black Americans. As a result, state decisions about whether to expand Medicaid have implications for efforts to address disparities in health coverage, access, and outcomes among people of color.

*Id. See also Status of State Medicaid Expansion Decision: Interactive Map*, *supra* note 41 (showing which states have expanded their Medicaid programs in accordance with the ACA, and which have chosen not to).

Medicaid, which leaves many individuals who otherwise would qualify under the Medicaid expansion, under or uninsured.[138]

If the federal government implements mental health telehealth as a required Medicaid category, there could be consequences in states that are unwilling to adopt mental health telehealth to their existing Medicaid program services as there was after the passage of the ACA.[139] While the federal government is prohibited from withholding federal money from states and thereby coercing them into complying with new federal regulations, incentives are not considered unconstitutional.[140] The *NFIB* Court cites examples of expanded coverage categories, and deems them permissible uses of federal power, such as the addition of pregnant women and children to Medicaid program coverage during the Clinton Administration.[141]

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[138] *See* Garfield et al., *supra* note 38 (describing in detail the effects on the uninsured poor in those states that refused Medicaid expansion).

> Adults left in the coverage gap are spread across the states not expanding their Medicaid programs but are concentrated in states with the largest uninsured populations. More than a third of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility. Nineteen percent of people in the coverage gap live in Florida, twelve percent in Georgia, and ten percent in North Carolina. There are no uninsured adults in the coverage gap in Wisconsin because the state is providing Medicaid eligibility to adults up to the poverty level under a Medicaid waiver.

*Id.* Garfield and Orega note that those in the coverage gap are likely to work low-wage jobs, which often disqualifies them for employer-based insurance coverage, and they also will not be eligible for ACA Marketplace premium subsidies because of the high cost associated with the Marketplace plans. *Id.*

[139] *See NFIB*, 567 U.S. at 583 (noting the difference between using the Congressional Spending power to alter by "degree" rather than change programs completely). The Court says that Congress can "use its spending power to create incentives for States to act in accordance with federal policies." *Id.* at 577. However, Congress cannot use "financial inducements to exert a 'power akin to undue influence.'" *Id.* (quoting Steward Mach. Co. v. Davis, 301 U.S. 548, 590 (1937)).

[140] *See id.* at 584 (finding that Congress cannot surprise the states with legislation that goes beyond the original agreement they made with the federal government when they first adopted the Medicaid program). A state can alter or amend the Medicaid program, but they cannot "transform it so dramatically" that it becomes a "post-acceptance or retroactive condition." *Id.*

[141] *See* Pear, *supra* note 117 (detailing the administrative policies Clinton passed which offered Medicaid coverage to working poor populations who had not qualified previously). Clinton revamped the welfare system, but arbitrary rules, such as one which disqualified someone Medicaid if they worked over 100 hours a

This is cited by Chief Justice Roberts as a shift in "degree" and not a shift in "kind."[142] Similarly, the addition of mental health services through telehealth could be an expansion in degree, as it could be added to the category of physician services already provided.[143] It is possible to add mental health services through telehealth as a required Medicaid category, so long as the addition is not unduly coercive to the established state programs.[144] Therefore, the federal government could offer to pay for the services, or offer something in return to the states who are unlikely to comply.[145]

## V. Conclusion

month actually disincentivized people to work. *Id.* It was a choice for states to adopt this new policy. *Id. See also* Oberlander, *supra* note 98, at 472 (describing the Clinton administration's failure to enact broad reaching healthcare reform). Although Clinton attempted to pass sweeping healthcare reform in a time when very few poor Americans had health insurance, the plan came nowhere near passing even though Democrats had control of both the House and the Senate. *Id.* The ACA was a more aggressive attempt to pass healthcare reform because of the lessons reformers learned from the Clinton administration's shortcomings. *Id.*

[142] *See NFIB*, 567 U.S. at 584–85 (disputing Justice Ginsburg's claims). The alteration Justice Ginsburg was referencing was an amendment which required States to cover pregnant women and increase the number of children covered under state Medicaid plans. *Id.* at 584–85.

[143] *See id.*at 585 (defining the limits of Congress' Spending Power, and the permissible uses).

> Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.

*Id.*

[144] *See id.* at 588 (describing what Congress may and may not do when offering grants to the states).

> Congress may offer the States grants and require the States to comply with accompanying conditions, but the States must have a genuine choice whether to accept the offer. The States are given no such choice in this case: They must either accept a basic change in the nature of Medicaid, or risk losing all Medicaid funding. The remedy for that constitutional violation is to preclude the Federal Government from imposing such a sanction.

*Id.*

[145] *See NFIB*, 567 U.S. at 588 (articulating the difference between offering conditions to a grant and creating a genuine choice rather than coercing the states).

The COVID-19 pandemic undoubtedly led to unprecedented heartbreak and hardship for many Americans, which triggered the onset or aggravation of mental health issues. It is understandable that many yearned for life to return to its pre-pandemic state; however, the advent of telehealth as a formidable counterpart to in-person healthcare is a silver lining in an otherwise bleak outlook. Access to mental health services through telehealth has greatly increased relief for those suffering from mental health issues, especially within communities that traditionally have not sought mental health services. Expanding Medicaid coverage to permanently include telehealth for mental health services as a required category of care could continue to serve low-income and minority populations forever. By leveraging the ruling in *NFIB v. Sebelius*, Medicaid could provide incentives to states in return for including mental health telehealth services as a covered category to avoid issues concerning coercion. The United States has a long way to go in addressing the social determinants and racial disparities in health but offering national access to mental health services could be a step in the right direction.