Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration

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Chair Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee, thank you for the opportunity to testify today regarding two issues that are integral to the effective treatment of behavioral health disorders: enforcement of behavioral health parity and the integration of behavioral and physical health treatment.

My name is Andy Keller, and I lead the Meadows Mental Health Policy Institute (Meadows Institute), a Texas-based non-profit and policy research institute committed to helping Texas and the nation improve the availability and quality of evidence-driven mental health and substance use care. The Meadows Institute provides independent, nonpartisan, data-driven, and trusted policy and program guidance that creates systemic and equitable changes, so all people can obtain effective, efficient behavioral health care when and where they need it. We are committed to helping Texas become a national leader in treatment for all people suffering from mental illness and addiction. More on our work and history can be found on our website.[1]

America's Behavioral Health is Worse Than Ever, Despite Decades of Bipartisan Consensus on the Need for Parity

America has long faced a behavioral health crisis, one that has been greatly exacerbated by the COVID-19 pandemic:

- While overall rates of death from suicide dropped slightly in the last two years after nearly two decades of increase,[2] deaths from suicide continued to increase for Black, indigenous, and Hispanic subgroups.[3] Suicide is now the fourth leading cause of life-years lost,[4] resulting in nearly $70 billion per year in medical costs and lost productivity.[5]
- Overdose deaths continue to rise, reaching an all-time high in 2020 of nearly 92,000 deaths, with rates of overdose deaths climbing a staggering 31% from 2019 to 2020.[6]
- Underlying indicators of depression increased four-fold during the pandemic, affecting nearly one-third of Americans.[7] Rates are currently three times higher than baseline.[8]
- In late 2021, the U.S. Surgeon General issued America's first ever public health advisory focused on mental health for the nation's youth.[9] The proportion of youth emergency department visits for mental health needs increased by almost one-third during the COVID-19 pandemic,[10] and by summer 2021 the rate of pediatric emergency room visits for suicide was double pre-pandemic levels.[11]

These consequences fall hardest on Black, indigenous, Hispanic, and other people of color, who generally receive inequitable and less culturally responsive care, with access to care often frustrated by language and cultural barriers, treatment inaccessibility, and premature care termination.[12] The burden of racism adds yet another insidious and toxic stress that increases risks of poor health for a range of health outcomes, including mental illness and addiction.[13] The COVID-19 pandemic exacerbated these effects, with Black and Hispanic adults more likely to report symptoms of anxiety and depression.[14] People of color have also disproportionately shouldered the burden of negative financial impacts[15,16,17] and of grief – a primary driver of

mental illness and addiction.[18,19,20] The pandemic resulted in the loss of at least 140,000 primary caregivers,[21] with disproportionate losses among American Indian, Black, and Hispanic children.

Behavioral Health Spending Has Consistently Failed to Keep Up with Needs

The simplest explanation for these consistently worsening behavioral health indicators is that we have dramatically cut spending on behavioral health over the last 40 years.[22] In 1986, behavioral health represented 9.3% of all medical spending. But a host of policy decisions, including the shift among insurers to manage behavioral health as a cost-center separate from other health conditions, led to extensive spending reductions. By 1998, behavioral health spending had been reduced by at least 20% more than other health care spending, to just 7.4% of all medical spending, and these decreased spending levels held constant going forward.

The budget of the Substance Abuse and Mental Health Services Administration (SAMHSA) is also illustrative. Between FY 2007 and FY 2017, SAMHSA's budget hovered between $3.2 billion and $3.6 billion a year. Since then, recognition of the unprecedented surge in substance use disorders and mental health needs has driven federal and state spending upwards. The FY 2022 SAMHSA budget is nearly six billion dollars higher – an exponential increase in funding in five years.

However, nearly four decades of services erosion cannot be fixed overnight, and to offset the trajectory we are on, we will need both the public and private sectors as part of the solution.

Behavioral Health Parity Is a Longstanding & Ongoing Concern

It has been more than 25 years since President Bill Clinton signed the Mental Health Parity Act, providing the first parity protections for people with mental health conditions. And it was almost exactly twenty years ago that President George W. Bush's New Freedom Commission on Mental Health called out "the unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance."[23] Those efforts culminated with the passage of the groundbreaking Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act (MHPAEA) in 2008. President Barack Obama expanded these protections across all private payers in 2010 with the Affordable Care Act.

Unfortunately, despite attention from Congress and Presidential Administrations for decades, parity implementation gaps persist, with millions of Americans unable to access needed behavioral health services. A 2019 Milliman research report detailed widespread network adequacy and reimbursement parity concerns for commercially insured consumers:[24]

- Commercially insured individuals were between five and six times more likely to use out-of-network providers for their behavioral health needs than for other healthcare.

- Primary care reimbursements were 19.8 to 28.3% higher than behavioral health reimbursements, and medical/surgical specialty visits were 17.0 to 18.9% higher.

And in January of this year, the Department of Labor (DOL), Department of Health and Human Services (HHS), and the Treasury released *The Report to Congress on Implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*.[25] In what the three departments termed "a failure to deliver parity," the report found broad non-compliance with MHPAEA's requirements among health insurance plans, with all 58 plans reviewed failing to meet requirements. Specific alarms were raised regarding the use of non-quantitative treatment limitations (NQTLs),[26] which are non-numerical limits on the scope or duration of benefits for treatment (such as pre-authorization requirements, differences in provider availability, and application of medical necessity standards).

The report emphasized many specific examples of the inappropriate use of NQTLs, including the exclusion of certain medicines as treatment for substance use disorder conditions and requiring pre-certification for all mental health and substance use disorder outpatient services as opposed to only for a limited range of medical/surgical outpatient care.

While it is important to acknowledge that insurers face systemic challenges in meeting network adequacy requirements for behavioral health care, the data clearly show that they are able to do so for all other medical/surgical specialties. While there is work to be done to improve consensus on standards and further clarity both reporting and parity requirements themselves, the simple fact that every single plan failed to meet expectations underscores the wide gulf between the promise of parity and the realities facing Americans in need of mental health and substance use disorder care today.

The Meadows Institute supports the departments' call for enhanced MHPAEA enforcement and recognizes the need for regulators, effected consumers, and the insurance industry to continue to improve reporting processes and agreed-upon practices. Additionally, the Meadows Institute encourages Congress to vest DOL with the authority to assess civil monetary penalties for parity violations and to amend The Employee Retirement Income Security Act of 1974 (ERISA) to expressly provide DOL with the authority to directly pursue parity violations by entities that provide administrative services to ERISA group health plans.

Medicare-specific Parity Concerns

These failures also affect Medicare beneficiaries. In 2020, Medicare spending reached $829.5 billion, accounting for 20% of total national health care expenditures.[27] Despite this, Medicare beneficiaries served through both fee-for-service and stand-alone Medicare Advantage plans do not enjoy the protections of MHPAEA. Consequently, the approximately one in four Medicare beneficiaries estimated to have a mental illness are subject to a range of behavioral

health treatment limitations that do not apply to Medicare-covered medical/surgical services.[28] These limitations also have broader systematic consequences beyond their direct impact on Medicare beneficiaries, because Medicare also plays an important role in setting rates, benchmarks, and codes for other health coverages.

Medicare imposes both quantitative and non-quantitative treatment limitations. Arguably, the most glaring example of a discriminatory quantitative Medicare limitation is the 190-day lifetime limit on inpatient psychiatric care. This discriminatory limitation restricts a Medicare beneficiary to just 190 days of inpatient care in their lifetime – without consideration of treatment necessity. A Medicare beneficiary disabled because of a chronic serious mental illness may easily exceed the 190-day lifetime limit, especially if they gain Medicare coverage at a younger age. **We support the Medicare Mental Health Inpatient Equity Act (H.R. 5674 / S. 3061), which would remove the artificial 190-day limitation.**

Network Adequacy: The data show that Medicare Advantage (MA) beneficiaries often lack access to in-network mental health providers, and metrics are often insufficient to ensure an adequate network of providers. This forces participants to turn to higher-cost, out-of-network care or to forego care entirely. A Kaiser Family Foundation analysis found that, on average, MA plans included less than one-quarter of psychiatrists in a county, and more than a third included less than 10% of psychiatrists in their county.[29] Medicare also imposes numerous NQTLs that would otherwise violate MHPAEA, including prior authorization requirements and limitations on providers and behavioral health services. As seen with the commercial plans, administrative burdens posed by NQTLs are often just as significant a barrier as low reimbursement rates.

Prior Authorizations: MA plans are often subject to burdensome, unnecessary prior authorization requirements. According to the Kaiser Family Foundation, four in five MA enrollees are in plans that require prior authorization for some services, and more than half of enrollees are in plans that require prior authorization for mental health services.[30] The prior authorization process has been shown to be wasteful and to potentially contribute to clinician burnout.[31] A 2017 American Medical Association survey of 1,000 physicians further noted that 92% of those surveyed reported that prior authorizations have a negative impact on patient clinical outcomes.[32]

Evidence-Based Care for Severe Needs: Medicare, along with most commercial plans and many Medicaid plans, also fail to cover a number of evidence-based, multi-disciplinary team interventions for people with the most severe mental health and substance use disorders. This includes Coordinated Specialty Care for early psychosis and Assertive Community Treatment (ACT) teams for people with persistently severe needs. The value and cost savings associated with the use of ACT teams has been established over decades of research.[33, 34] Coordinated

Specialty Care (CSC) has been shown to produce greater improvement in clinical and functional outcomes as compared with standard care for those experiencing first-episode psychosis.[35, 36]

Crisis Care: Medicare also fails to cover mental health crisis services, a failure mirrored in commercial coverage. As we roll out the 988 crisis number nationally and as communities across the nation work to establish a full continuum of crisis services, that failure is unacceptable. Earlier this year, we joined RI International and the National Association of State Mental Health Program Directors to publish Sustainable Funding for Mental Health Crisis Services, which identifies standardized existing healthcare codes that every insurer should reimburse, including Medicare.[37] The Meadows Institute is very appreciative to Senator Wyden for his continued leadership on the need to adequately fund and support crisis care and to Senators Cornyn and Cortez Masto for focusing on the important role that insurance coverage must play in supporting crisis care. **We strongly support Senators Cornyn and Cortez Masto's Behavioral Health Crisis Services Expansion Act (S. 1902), which would expand reimbursement for the full spectrum of crisis services under Medicare and other payers.**

Peer Support: Similarly, peer support services are not covered within Medicare. Peer support services are provided by people with lived experience of a mental illness or substance use disorder who have completed specialized training and are certified to deliver support services under appropriate state or national certification standards. A 2018 analysis showed that providers with peer services had 2.9 fewer hospitalizations per year and saved an average of $2,138 per Medicaid enrolled month in Medicaid expenditures.[38] **We support Senators Cortez Masto and Cassidy's Peers Act of 2021 (H.R.2767/ S. 2144), which would specify that peer support specialists may participate in the provision of behavioral health integration services with the supervision of a physician or other entity under Medicare.**

Substance Use Disorder Care: There are also major gaps in access to substance use disorder (SUD) care in Medicare, Medicaid, and commercial plans. Broadly speaking, we support the positions set forth by the Medicare Addiction Parity Project. Despite a significant number of Medicare beneficiaries requiring SUD treatment, Medicare simply does not adequately cover most essential SUD benefits and services. SUD services within MA, especially services and medications for opioid use disorders (OUD), are disproportionately subject to burdensome and unnecessary prior authorization requirements and other limitations that hinder timely access to appropriate medications and services.

There is also a significant issue with SUD network adequacy and a lack of SUD providers covered by Medicare. Providers that are not covered by Medicare include Licensed Professional Counselors, Licensed Addiction Counselors, Certified Alcohol and Drug Counselors, and Peer Support Specialists. As a result, many patients who seek treatment are unable to access it.

For Medicare and commercial health plans alike, we are particularly concerned about barriers to access for Medication-Assisted Treatment (MAT). An analysis we conducted in August 2020 showed that universal access to MAT could have saved almost at least 24,000 lives annually from overdose.[39] There are also coverage, prior authorization, and network adequacy barriers to MAT in essentially all health plans.

The Most Important Reform: Integration of Behavioral Health into Primary Care

The primary impediment to parity is the lack of providers to deliver care cost-effectively, and integration of behavioral health providers and care deliver into primary care offers the only path to removing this barrier. To adequately address the magnitude of behavioral health need in America, we must combine enhanced parity enforcement with an aggressive effort to integrate behavioral health into primary care. Broad scale adoption of evidence-based primary care interventions for mental health and substance use disorders are essential to realizing the promise of parity for two reasons. First, decades of research and over 90 randomized control trials have clearly shown that the two-thirds of needs which fall into the mild to moderate range can be better treated in primary care than in specialty care.[40] Second, serving most people in primary care would allow America's limited specialty care workforce to focus on people with more severe and complex needs.

Currently, our behavioral health workforce is not well-deployed upstream in U.S. primary care settings as compared to other industrialized nations.[41] This is a major reason why we fail to detect and treat mental health needs until eight to ten years after symptoms emerge.[42] But America faced this same challenge with heart disease and cancer and successfully turned the tide on both by leveraging primary care over the last four decades. Until the 1980s, we identified heart disease primarily when a person had a heart attack, and we began treatment then, after the heart was damaged, to resuscitate the person and prevent a recurrence. We would also wait to detect cancer until it resulted in functional impairment – a broken bone, coughing up blood – with devastating consequences and higher mortality rates. Today, we have systems in place in primary care to detect and treat most heart disease and many cancers much earlier, when they are easier to address successfully, much less likely to be disabling and burdensome to the person receiving care, and less costly to society.

Two models best represent the promise of reaching people in primary care rather than referring them to overwhelmed and understaffed specialty care systems: 1) the Collaborative Care Model (CoCM) and 2) Primary Care Behavioral Health (PCBH). CoCM and PCBH each have the potential to magnify the reach of our limited workforce many times over, and analysis carried out by the Meadows Institute shows that CoCM can leverage psychiatrist time 3.5 times over and PCBH can leverage other licensed practitioner time 2.65 times over.[43] In early 2021, comprehensive studies through both RAND and the Bipartisan Policy Center endorsed these strategies,[44] and RAND offered specific recommendations for scaling them nationwide.

CoCM is the most extensively researched and evidence-based integration strategy to detect and treat mental health and substance use disorders before they become crises,[45] and it is now being implemented at scale in health systems serving millions of Texans.[46] The potential cost-savings of widespread implementation are considerable: a pivotal 2013 study found Medicare and Medicaid savings of up to six-to-one in total medical costs and estimated $15 billion in Medicaid savings if only 20% of beneficiaries with depression received it,[47] and the RAND report cited a 13:1 return on investment. Importantly, CoCM is proven to work just as well for Black, Hispanic, and other communities of color,[48] and PCBH has shown growing promise with pediatric populations.[49]

Though certain distinctions exist between the two approaches, both effectively address pediatric workforce shortages by: (a) sharing an interdisciplinary team-based structure, (b) treating a wide array of behavioral health presentations, (c) leading to stigma-reduction, (d) utilizing evidence-based measures to guide treatment planning and monitoring, (e) having dedicated insurance billing codes for long-term financial sustainability for practices, (f) allowing for real-time availability of behavioral health care, and (g) employing brief, evidence-based interventions in a short-term care format to help patients access care sooner. Both CoCM and PCBH rely on approved existing billing codes that are reimbursed by Medicare, most major commercial insurance plans, and most states' Medicaid plans. Texas, of note, is expected to activate Medicaid reimbursement for CoCM in CY 2022, which is helping to drive implementation of CoCM and integration broadly.

However, coverage alone is not enough. As the RAND report previously noted, CoCM and PCBH are not available in most primary care settings today, with "implementation of models like CoCM . . . underwhelming and largely confined to academic medical centers." Given this, the RAND report recommends a nationwide effort to provide technical assistance and financial incentives scaled in the hundreds of millions of dollars to help the hundreds of thousands of primary care practitioners across the nation rapidly adopt these models.

Only a national effort of this magnitude can turn the tide on rising deaths from suicide and overdose. America faced this same challenge 15 years ago regarding the adoption and meaningful use of electronic health records, and we employed technical assistance and financial incentives to scale their availability nationally in just a few years. If we wait 20 years, this will be the standard of care nationwide, but in the meantime we will lose over two million more Americans to suicide and overdose and relegate tens of millions more to poor access, delayed care, and a range of tragic outcomes.

Today in Texas we are showing that such a rapid transition is possible. Over the next five years, the Meadows Institute and our partners are using the $10 million Lone Star Prize awarded by Lyda Hill Philanthropies to bring this care to over 10 million Texans.[50] In addition, Texas is

deploying $7 million in American Rescue Plan Act (ARPA) funds to accelerate implementation of integration in pediatric settings to increase access across 18 Texas health systems.

Congressional efforts such as the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) by Rep. Fletcher (D-TX) and Rep. Herrera Beutler (R-WA) could form the basis for such action, and this effort is supported by every major medical association.[51] To address the magnitude of the national crisis facing us today, this legislation should be broadened to include PCBH and scaled up to funding levels sufficient for national scaling such as those recommended by RAND.

The Meadows Institute encourages the Committee to support large-scale efforts to build integrated care infrastructure and widescale adoption of models such as CoCM. We also encourage the Committee to support the Collaborate in an Orderly and Cohesive Manner Act (H.R. 5218) to help primary care providers implement integrated behavioral health and primary care models, but broaden it to cover models such as PCBH and expand its reach by funding it at levels suggested by the RAND report as necessary for widescale adoption.

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[1] The Meadows Institute website can be viewed here: https://mmhpi.org; our latest policy work here: https://mmhpi.org/work/policy-updates/; and our history here: https://mmhpi.org/about/story-mission/

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