



UNITED STATES SENATE

# COMMITTEE ON FINANCE

PRESENTS



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# MENTAL HEALTH CARE IN THE UNITED STATES

## THE CASE FOR FEDERAL ACTION

## Contents

<b>Letter from Chairman Ron Wyden</b> .....	1
<b>Chapter 1. Report Purpose</b> .....	3
<b>Chapter 2. Behavioral Health Definitions, Prevalence, and Spending</b> .....	4
<b>Chapter 3. Status of the Behavioral Health Workforce</b> .....	8
<b>Chapter 4. Children, Adolescents, and Young Adults</b> .....	12
<b>Chapter 5. Access, Integration, and Coordination</b> .....	17
<b>Chapter 6. Mental Health and SUD Parity</b> .....	21
<b>Chapter 7. The Role of Telehealth</b> .....	25
<b>Chapter 8. Next Steps</b> .....	29
<b>Appendix A. Senate Committee on Finance Hearings on Behavioral Health in the 117th Congress</b> ..	30
<b>Appendix B. Timeline of Federal Mental Health and SUD Parity Laws</b> .....	31

## Letter from Chairman Ron Wyden

The United States is experiencing a profound crisis when it comes to mental health care. In a recent Senate Committee on Finance hearing on youth mental health, U.S. Surgeon General Dr. Vivek Murthy shared that Americans wait 11 years, on average, between onset of mental health symptoms and first receiving treatment. This gap is staggering. The consequences are plain to see: higher suicide and drug overdose rates, more Americans without a safe place to sleep at night, more children experiencing depression and anxiety that will compound as they grow into adulthood. The house is on fire, and the nation is short on firefighters equipped to put out the blaze. This crisis has been made even worse by the disruption, isolation, and loss experienced in the COVID-19 pandemic.

This issue is deeply personal for me. For years, my brother struggled to access the mental health care he needed and our family struggled against the painful stigma that has surrounded mental illness for as long as I can remember. It is a tragedy that helping a loved one get care is still a challenge for millions of other families around the country.

I hear about the challenges of getting mental health care every time I visit communities in my home state of Oregon. Mental health is the premier concern for families across my state because their loved ones need help and too often are unable to find it. More people are in crisis and there are fewer people to take care of them. Oregon's rate of unmet need for mental health treatment is one of the highest in the nation, ranking behind just three other states. One in five youth had a major depressive episode last year, and less than half received care. Among adults, 43% of adults in Oregon who reported any mental illness received treatment. People are calling for help. Youthline, a peer-to-peer crisis line has seen a 15% increase in calls.

As Chairman of the Senate Finance Committee, I am partnering with Ranking Member Mike Crapo on a major bipartisan effort to bring behavioral health care to the forefront of the U.S. health system by leveraging the programs under this Committee's jurisdiction, including Medicare, Medicaid, and the Children's Health Insurance Program. Ten members of the Committee – five Democrats and five Republicans – have stepped forward to lead on policy areas that will be vital for a path forward, including: Senators Debbie Stabenow and Steve Daines on the behavioral health workforce; Senators Catherine Cortez Masto and John Cornyn on care integration, coordination, and access; Senators Michael Bennet and Richard Burr on mental health parity; Senators Ben Cardin and John Thune on telehealth; and Senators Tom Carper and Bill Cassidy on improving care for children and young people.

The Committee's work has begun. In the fall of 2021, the Committee issued a public request for information that received 300 submissions from experts and advocates around the country. The Committee has held hearings bringing together leaders, providers and patients who shared their stories and offered solutions. From these testimonies, and staff review of relevant

research, a number of facts have come to light as presented in this report. These facts can inform the Committee's work ahead:

First, the mental health care system needs a strong workforce able to provide appropriate care where people are—whether that's in schools for youth, community clinics, residential programs, hospitals, or virtually by telehealth.

Second, reforms must connect people to the care they need at the right time. That means improving connections between Americans experiencing symptoms or crisis and mental health and substance use disorder clinicians and primary care, removing barriers to tele-mental health care, and ensuring young people and adults get care early on before conditions worsen or escalate.

Third, insurance companies must be held accountable for putting mental health care on par with physical care. Medicare, Medicaid, and CHIP must also deliver on the promise of parity. There can be no cutting corners in mental health and SUD coverage.

Across all of these issues, there must be a recognition of the disparities that underlie our health care system: including racial, ethnic, sexual identity, and geographic disparities. These disparities contribute to inequities in mental health and SUD outcomes. Closing these gaps requires addressing disparities in access to care and coverage, and creating a more connected, inclusive and diverse mental health workforce.

This report marks the Finance Committee's next step in the bipartisan effort to understand the behavioral health care crisis in the U.S. and, further, to craft a legislative package, which the Committee intends to consider this summer. As I see it, the Committee's lodestar must be this: every American is able to access the mental health and substance use disorder care they and their loved ones need when they need it.



Ron Wyden  
Chairman

## Chapter 1. Report Purpose

The Senate Finance Committee is responsible for developing legislation and providing oversight of federal programs that finance and provide health coverage for more than 120 million Americans under Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), Affordable Care Act (ACA) marketplace coverage, and group health plans as defined by section 5000(b)(1) of the Internal Revenue Code of 1986. The Committee has an obligation to study the health challenges facing the individuals with coverage under these programs and to propose modifications and reforms as needed.

This report brings together the work of the Committee during the 117<sup>th</sup> Congress to understand the behavioral health challenges in America. The purpose of the report is to support the current bipartisan initiative being undertaken by the Committee to improve behavioral health for Americans covered under federal health programs. The Committee takes a broad view of behavioral health to include both mental health conditions and SUD, reflecting the reality that mental health and SUD are often, though not always, co-occurring.

Thus far, the Committee has conducted public fact-finding efforts through three hearings specific to behavioral health (described in Appendix A) and a bipartisan request for information (RFI). In response to the RFI, the Committee received 321 submissions from organizations and coalitions and 229 submissions from individuals. This work benefited from the discussions of community-based approaches to behavioral health care led by Chairwoman Stabenow and Ranking Member Daines in the Subcommittee on Health. This report also reflects information gathered through numerous meetings with constituents and experts, as well as a robust review of literature on behavioral health care published by federal agencies and researchers.

This report has seven chapters. Chapter 2 summarizes the prevalence rates of behavioral health conditions in the U.S., the impact of the COVID-19 pandemic, and spending on behavioral health. Subsequent chapters outline key challenges across five cross-cutting areas: status of the workforce; children, adolescents and young adults; access to care, integration, and coordination; mental health and SUD parity; and telehealth. In each area, we find greater challenges facing individuals with social risk factors and those living in rural and urban underserved areas.

### Key Terms

**Behavioral health conditions** include mental health and substance use disorders (SUD).

**Mental health conditions** can include mild to severe conditions including autism, depression, anxiety, bipolar disorder and schizophrenia.

**SUD** refers to chronic health conditions wherein recurrent substance use causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

**Medicare** provides health care coverage for more than 60 million adults 65 and older and individuals with disabilities.

**Medicaid** provides health care coverage for over 75 million children and adults living with low incomes.

**Children’s Health Insurance Program (CHIP)** provides health care coverage for nearly 7 million children.

**ACA Marketplaces** provides insurance for more than 14 million people in the individual and small group market.

## Chapter 2. Behavioral Health Definitions, Prevalence, and Spending

This chapter provides information on the prevalence of behavioral health conditions in the U.S., describes the impact of the COVID-19 pandemic for people struggling with these conditions, and reviews estimates of behavioral health spending.

*Mental health conditions.* Approximately one in five adults in the U.S. suffers from a diagnosable mental health illness each year. Individuals with low-income or those living in underserved communities experience even higher rates.<sup>1</sup>

*Severe mental illness (SMI).* SMI is defined as a mental, behavioral, or emotional disorder resulting in functional impairment and may include diagnoses such as severe depression, bipolar disorder, or schizophrenia.<sup>2</sup> In 2020, an estimated 5.6% of adults (14.2 million people) were living with SMI.<sup>3</sup> People living with serious mental health illness have shorter life expectancies than the general population.<sup>4,5</sup>

*Substance Use Disorder (SUD).* SUD is common, affecting more than 40 million people ages 12 and older in 2020.<sup>6</sup> In 2020, an estimated 2.7 million people were living with opioid use disorder (OUD), but only 11% received medication for OUD in the past year.<sup>7</sup> About 8% of hospitalized adults with OUD died within 1 year of discharge – mortality rates that are similar to patients admitted with acute heart attacks.<sup>8</sup> SUD may co-occur with behavioral health conditions and nearly 10 million adults have both SMI and SUD.<sup>9</sup>

*Suicide.* Suicide is the tenth leading cause of death in the U.S. and the second leading cause of death among individuals between the ages of 10 and 34.<sup>10</sup> Among Black children 13 and younger the suicide rate is 2 times higher compared to White children.<sup>11</sup> In 2018, an estimated 10.6 million adults aged 18 or older had thought seriously about trying to end their lives.<sup>12</sup> In 2017, 1.5 million emergency department (ED) visits were related to suicidal ideation or a suicide attempt. Deaths by suicide have been increasing faster in rural communities than in urban communities and occur at a higher rate in rural areas.<sup>13</sup>

*Stigma.* The stigma associated with behavioral health conditions (e.g., negative attitudes or discrimination) plays a significant role in the ability of Americans to receive care they desperately need. Stigma can cause people to avoid or delay seeking or receiving treatment. The National Alliance of Mental Illness reports that eight out of 10 workers say shame and stigma prevent them from seeking

### Key Facts:

- Prior to the pandemic, more than 50 million Americans - 1 in 5 adults - reported any mental illness in the past year.
- Since the pandemic, mental health distress has skyrocketed as evidenced by an increase in overdose deaths, drug overdoses and suicide attempts.
- Suicide is the 2<sup>nd</sup> leading cause of death among individuals between the ages of 10 and 34.
- Stigma prevents many people who need behavioral health care from seeking out treatment.
- More than half of people who need mental health care do not receive it, with even higher rates of unmet need for racial and ethnic minority populations.



treatment for a mental health condition.<sup>14</sup> In addition, provider stigma—that is, negative perceptions of patients with SUD—is also a barrier to evidence-based treatment for substance use disorder.<sup>15</sup>

*COVID Impacts.* In April 2021, over a year into the COVID-19 pandemic, the Government Accountability Office (GAO) reported that the prevalence of mental health conditions had increased, along with the severity of those in crisis.<sup>16</sup> The GAO noted that prior to the pandemic, 11% of adults reported experiencing symptoms of anxiety or depression, whereas from April 2020 through February 2021, nearly 40% of adults reported symptoms of anxiety or depression. Emergency department (ED) visits for drug overdoses and suicide attempts were 36% and 26% higher, respectively, compared to the same time period in 2019. Overdose deaths also rose more than 20% in the first year of the pandemic.<sup>17,18</sup> At the same time, behavioral health providers have reported increasing demand with decreasing staff sizes.

Of particular concern, numerous studies and news reports have documented how youth mental health worsened during the pandemic. In response, pediatric clinicians and the children’s hospitals have declared a national emergency related to youth mental health. The Surgeon General issued an advisory, *Protecting Youth Mental Health*, in December 2021 describing how youth across the U.S. are experiencing significant and widespread mental health challenges, exacerbated by the COVID-19 pandemic.

*Underserved Areas.* While vastly different in environment, people living in both underserved urban and rural areas may face challenges in accessing behavioral health care.<sup>19</sup> There are over 6,000 mental health professional shortage areas (HPSAs) in the U.S., accounting for more than 135 million people: nearly 60% of these HPSAs are in rural areas and 33% are in non-rural areas.<sup>20</sup> Lack of reliable broadband internet also limits the availability of telehealth as an option for receiving behavioral health care in both rural and urban underserved areas.<sup>21</sup> Living in a rural or frontier community poses unique challenges to accessing behavioral health care, including greater distances to find care, which create financial and access barriers.<sup>22</sup> In addition, living in a smaller community may heighten concerns around the stigma of having a behavioral health condition, presenting additional barriers for some people seeking care and support.

*Health Disparities.* A number of studies have found that more than half of people who need mental health care do not receive it, with even higher rates of unmet need for racial and ethnic minority populations: 63% of Black adults, 65% of Hispanic and Latino adults, 80% of Asian and Pacific Islander adults do not receive care when needed.<sup>23</sup> Limited English proficiency can also be a barrier to accessing behavioral health care.<sup>24</sup> Disability resulting from mental health disorders often disproportionately impact people from racial and ethnic minority groups.<sup>25</sup> Despite growing rates of synthetic opioid use and overdose deaths among racial and ethnic minorities, racial and ethnic minorities are less likely to receive medications for OUD.<sup>26</sup> Studies also find higher rates of behavioral health conditions in LGBTQ populations<sup>27</sup> and among adolescents and young adults. The 2021 National Healthcare Quality and Disparities report identified stigma, cultural attitudes and beliefs, insurance coverage, and lack of diversity in the mental health workforce as contributors to potential drivers of the gaps in care for racial and ethnic minorities.<sup>28</sup>

*Behavioral Health Spending.* From 2006 to 2015, behavioral health spending across all payers in the U.S. grew by 62%, from \$131 billion to \$212 billion.<sup>29</sup> Over this time period, SUD spending increased from \$18 billion to \$56 billion, a 210% increase. The Substance Abuse and Mental Health Services Administration (SAMHSA) projected that in 2020, behavioral health spending would grow to be more

than \$280 billion. For 2020, Medicaid was projected to be the largest payer of behavioral health services in the U.S., accounting for 30% of total spending on these services, followed by private insurance. Medicare accounted for 13% of behavioral health spending.<sup>30</sup>

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<sup>3</sup> Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Service Administration, Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, 2021. HHS Publication No. PEP21-07-01-003, NSDUH Series H-56. Available at: <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>.

<sup>4</sup> World Health Organization, Premature death among people with severe mental disorders. Available at: [https://www.who.int/mental\\_health/management/info\\_sheet.pdf](https://www.who.int/mental_health/management/info_sheet.pdf).

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<sup>7</sup> Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, 2021. Available at: <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>

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<sup>9</sup> Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health, 2021. Available at: <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf>

<sup>10</sup> National Institute of Mental Health, "Suicide" Available at: <https://www.nimh.nih.gov/health/statistics/suicide>.

<sup>11</sup> Bridge JA, Horowitz LM, Fontanella CA, Sheftall AH, Greenhouse J, Kelleher KJ, Campo JV. Age-Related Racial Disparity in Suicide Rates Among US Youths From 2001 Through 2015. *JAMA Pediatr*. 2018 Jul 1;172(7):697-699. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6137506/>

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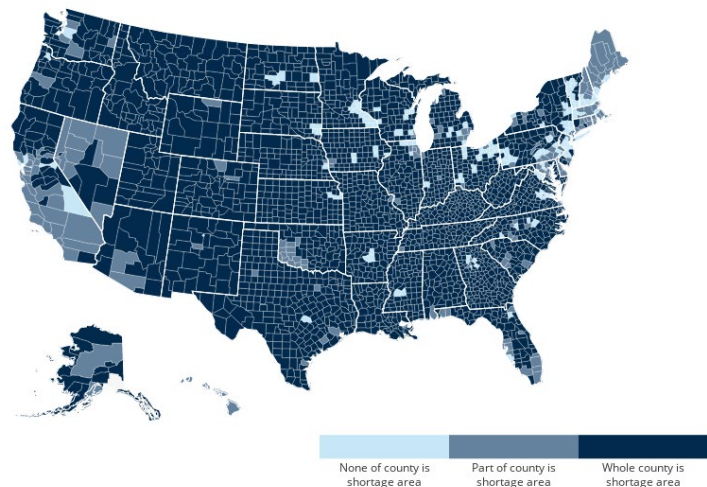
## Chapter 3. Status of the Behavioral Health Workforce

The behavioral health workforce consists of many types of providers, including psychiatrists, psychologists, addiction medicine clinicians, primary care clinicians, psychiatric nurse practitioners, psychiatric physician assistants, marriage and family therapists, licensed professional counselors, addiction counselors, social workers, school counselors, community health workers, and peer support specialists. Additionally, subspecialists within some of these broader categories focus on particular age groups or behavioral health challenges. Care delivery can also occur in a variety of settings, including primary care offices, mental health clinics, schools, outpatient partial hospitalization programs or day treatment programs, residential treatment centers, inpatient hospitals, and inpatient psychiatric facilities (IPFs).<sup>1</sup> This chapter summarizes the status of the behavioral health workforce in the U.S. and challenges in meeting demand.

*Workforce Shortages.* Although it is widely recognized that access to behavioral health providers is insufficient, data and projections of the extent of the workforce shortage are inconsistent. According to the Behavioral Health Workforce Report prepared by SAMHSA, the U.S. needs 4.4 million more behavioral health practitioners to meet current needs, based on the number of Americans diagnosed with SMI, SUD, and serious emotional disturbance.<sup>2</sup> However, the Health Resources and Services Administration (HRSA) found that there were only 6,000 too few providers in 2017 and projects a shortage of 24,060 providers in 2030.<sup>3</sup> HRSA projects this shortage to reflect insufficient adult psychiatrists and addiction counselors in 2030 if there are no changes in behavioral health care utilization and anticipates an adequate supply of remaining behavioral health practitioners to meet the needs of Americans.

The total number of providers is not the only challenge. The geographic distribution of providers can also create access gaps. Nearly one-third of Americans live in a mental health care health professional shortage area (see Figure).<sup>4</sup> More than 60% of all U.S. counties—including 80% of all rural counties—do not have a single psychiatrist.<sup>5</sup> In addition, access to clinicians who can offer evidence-based treatment for OUD is limited. According to the HHS Office of the Inspector General (OIG), two-thirds of counties have low or no capacity to provide medication-assisted treatment (MAT) for OUD, and among those counties with the highest need, 56% have inadequate MAT capacity.<sup>6</sup> Finally, access to providers is limited by the extent to which they participate in programs like Medicare and Medicaid. For example, only 36% of psychiatrists accept new Medicaid patients.<sup>7</sup>

Health Professional Shortage Areas: Mental Health, by County, 2022



Source: [data.hrsa.gov](https://data.hrsa.gov), January 2022.

*COVID-19 Impacts.* A 2021 GAO study reported that behavioral health providers found that meeting demand for behavioral health care services was a challenge prior to the pandemic, and that the COVID-19 pandemic had exacerbated these challenges.<sup>8</sup> The report noted that the demand for behavioral health services increased substantially in the early months of the pandemic, while many behavioral health providers were unable to take new patients or needed to care for fewer patients to facilitate social distancing. More than two-thirds of behavioral health providers reported “having to cancel, reschedule, or turn away patients in the last 3 months.”<sup>9</sup> During the COVID-19 public health emergency, the federal government and some states have provided for flexibility on the frequency for prescribing MAT and providing for greater use of telehealth, allowing for greater access to care.<sup>10</sup>

*Clinician Burnout.* The pandemic has been challenging for all health care workers and has contributed to fatigue and burnout. Close to half (42%) of nurse respondents answered “yes” when asked if they have had an extremely stressful, disturbing, or traumatic experience due to COVID-19, while 34% of nurses rated their emotional health status as not, or not at all, emotionally healthy.<sup>11</sup> This is also true for the behavioral health workforce. In a survey of 2,000 psychiatrists, 78% self-reported burnout and 16% screened positive for major depression.<sup>12</sup> The stress and occupational risks facing health care workers have intensified existing workforce shortages, undermining quality of care and putting the health of health care workers at risk.<sup>13</sup>

*Underserved Areas.* Workforce shortages impact residents of both urban and rural communities. Urban communities have higher populations of individuals experiencing homelessness or incarceration, substance use disorder, and severe mental illness.<sup>14</sup> While the existing behavioral health workforce is insufficient in number to meet the needs of all Americans, the predominantly urban distribution of the existing behavioral health workforce exacerbates barriers to care in rural areas. There are higher rates of SUD and suicide in rural communities, but 50% of rural counties do not have a psychiatrist, psychologist, or social worker. Only about 1.6% of psychiatrists in the U.S. live in rural areas.<sup>15</sup> Furthermore, the OIG found that rural counties were more likely to have low or no access to MAT.<sup>16</sup> More than 60% of rural Americans live in a designated mental health provider shortage area.<sup>17</sup> Licensed professional counselors and marriage and family therapists make up a 61% of the rural mental health workforce but are not eligible for payment under Medicare.<sup>18</sup>

*Racial and Ethnic Health Disparities.* The demographics of the behavioral health workforce do not reflect the racial and ethnic diversity of the U.S. population<sup>19</sup> or those with behavioral health conditions.<sup>20</sup> The lack of diversity in the workforce is a function of multiple factors including lack of access to pipeline programs and other training opportunities. In addition, clinicians who can deliver culturally and linguistically appropriate services have been found to improve patient care, but widespread adoption of these competencies is limited.<sup>21,22</sup>

#### Key Facts:

- A lack of available behavioral health care providers impedes access to care.
- The existing workforce does not reflect the racial and ethnic diversity of the U.S. population and access to their services is limited for people living in urban and rural underserved areas.
- The COVID-19 pandemic exacerbated challenges in accessing care and has resulted in many health care providers suffering from burnout.

*Future Direction.* The Committee received 256 RFI responses on how to strengthen the behavioral health workforce. Proposed solutions include creating pathways for behavioral health and primary care integration, expanding scholarship and loan repayment programs, developing educational pipeline programs, increasing graduate medical education funding, establishing tax credits to improve retention in rural and underserved areas, identifying ways to reduce clinician burnout and improve resiliency, and expanding eligible provider types for Medicare payment to include marriage and family therapists, licensed professional counselors, licensed addiction counselors, and peer support specialists.

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*Future Direction*. The Committee received 256 RFI responses on how to strengthen the behavioral health workforce. Proposed solutions include creating pathways for behavioral health and primary care integration, expanding scholarship and loan repayment programs, developing educational pipeline programs, increasing graduate medical education funding, establishing tax credits to improve retention in rural and underserved areas, identifying ways to reduce clinician burnout and improve resiliency, and expanding eligible provider types for Medicare payment to include marriage and family therapists, licensed professional counselors, licensed addiction counselors, and peer support specialists.

## Chapter 4. Children, Adolescents, and Young Adults

Behavioral health conditions often begin at a young age: 50% of adults with a behavioral health condition had symptoms by age 14, and 75% experienced symptoms by age 24.<sup>1</sup> This chapter summarizes recent evidence on the prevalence of behavioral health conditions among children, adolescents, and young adults, as well as on the drivers of behavioral health needs and barriers to care.

*Prevalence.* Up to one in five children ages 3 to 17 report a mental, emotional, developmental, or behavioral disorder.<sup>2</sup> Among young adults 18 to 25 years old, 30% are estimated to have a mental illness and 10% an SMI – the highest burden across all age groups.<sup>3</sup> In 2020, more than 24% of young adults reported a SUD in the past year.<sup>4</sup> The opioid overdose mortality rate for children and adolescents under the age of 20 has tripled in the past two decades, with prescription opioids accounting for about one-third of overdose-related fatalities among 15 to 19 year olds in 2016.<sup>5</sup> Although most deaths by suicide occur among adults, deaths by suicide among individuals 10 to 24 years old increased by 57% between 2007 and 2018.<sup>6</sup>

Mental health challenges vary across subpopulations. Girls, for instance, are more likely to be diagnosed with anxiety, depression, or an eating disorder, whereas boys are more likely to die by suicide or be diagnosed with a behavioral disorder such as attention deficit hyperactivity disorder.<sup>7</sup> One study found that 42% of LGBTQ youth had considered attempting suicide in the past year.<sup>8</sup> Additionally, children who have experienced adverse childhood experiences, including exposure to violence and abuse, are at greater risk for mental health and SUD conditions.<sup>9</sup> To this end, youth involved with the child welfare system also have higher rates of behavioral health needs, with almost 50% of these youth estimated to have a mental health disorder.<sup>10</sup> Justice-involved youth also experience high rates of behavioral health concerns.<sup>11</sup>

*Unmet needs.* Research suggests that in 2016, about half of the 7.7 million children with treatable mental health disorders did not receive adequate treatment.<sup>12</sup> Less than 15% of children in low-income households receive mental health services, and even fewer complete treatment.<sup>13</sup> Similar to adults, fewer than 10% of adolescents and young adults with an SUD received any SUD treatment.<sup>14</sup> Accessing outpatient psychiatric appointments has presented longstanding challenges, as many children wait an average of one month before being seen by a psychiatrist, in part due to low participation rates by these providers in Medicaid.<sup>15</sup> There are currently 9.75 child psychiatrists per 100,000 children<sup>16</sup> but a number of experts recommend there should be four times as many.<sup>17</sup> In addition to psychiatrists, there are shortages of other child-serving providers as well, such as child and adolescent psychologists and school

### Key Facts:

- Mental health and SUD challenges worsened among youth during the years leading up to COVID-19, and have reached crisis levels in the wake of the pandemic.
- Special attention should be paid to youth at higher risk for mental health and SUD concerns, including youth involved with the child welfare system.
- Youth can receive care in a range of clinical and non-clinical settings such as schools, which play a major role in facilitating access to mental health services today.



counselors. For example, out of the 102,000 total psychologists nationwide, only 4,000 are clinical child and adolescent practitioners.<sup>18</sup>

While telehealth has reportedly provided some relief for children by providing access to services, experts note that telehealth services may not be universally appropriate, as some children may lack sufficient privacy at home, and others may be too young.<sup>19</sup> Youth also often face higher barriers to SUD care. For example, only one-fourth of addiction treatment facilities offer adolescent programs, and these facilities are half as likely as adult facilities to provide medications for OUD.<sup>20</sup> Between 2009 and 2015, only one in 54 youths received recommended evidence-based pharmacotherapy after an opioid overdose.<sup>21</sup>

*COVID-19 impacts.* The state of youth mental health worsened during the pandemic as children and young adults faced unprecedented challenges, ranging from dramatic shifts in social interactions and schooling to the tragic loss of family members and caregivers. As of June 2021, more than 140,000 children in the country lost a parent or grandparent caregiver to COVID-19. Two-thirds of these children were racial and ethnic minorities.<sup>22</sup> Depressive and anxiety symptoms have doubled during the pandemic, with 25% of youth experiencing depressive symptoms and 20% experiencing symptoms of anxiety.<sup>23</sup> In early 2021, ED visits for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to rates for the same period in 2019.<sup>24</sup>

*School-based health services.* Schools provide an important access point to behavioral health services. Prior to the pandemic, approximately 3.7 million adolescents accessed mental health care through schools, and those services are primarily financed through Medicaid.<sup>25</sup> School-based interventions have been found to improve mental health outcomes and reduce SUDs among youth.<sup>26</sup> Youth are often more likely to seek support in a school-based setting, and research has shown that school-based health centers that offer mental and physical health services help to reduce behavioral health issues.<sup>27,28</sup>

*Underserved areas.* Youth in rural and urban underserved areas face unique challenges that impact their mental health care. Rural and urban underserved areas have a shortage of behavioral health providers, and rural areas have fewer clinicians who can offer MAT.<sup>29,30,31</sup> At the same time, youth in rural areas report high mental health needs, and rural youth are almost twice as likely to die by suicide as youth in urban areas.<sup>32</sup> Research on urban youth has found that living in neighborhoods with high poverty and unemployment rates can have indirectly negative effects on youth mental health.<sup>33</sup>

*Racial and Ethnic Health Disparities.* Racial and ethnic minority youth experience higher rates of mental illness, but are less likely to receive care, including school health services.<sup>34</sup> Suicide attempt rates are decreasing among White children, however, suicide attempts for Black children have increased by 73% from 1991 to 2017.<sup>35</sup> Studies also suggest that Asian American children may have higher unmet mental health needs, compared to White children.<sup>36</sup> Disparities in access to and receipt of SUD treatment among racial and ethnic minority adolescents also exist.<sup>37,38,39</sup>

*Future Direction.* The Committee received 171 responses to the RFI addressing youth mental health. Recommendations included, in part, increasing and investing in school-based mental health services, removing barriers to school-based Medicaid programs, telehealth parity (including audio-only telehealth), increasing telehealth in school-based mental health services, and investing in funding for training and loan repayment programs for the pediatric mental health workforce.

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## Chapter 5. Access, Integration, and Coordination

Access to the right behavioral health care at the right time requires not only access to clinicians, but also information exchange and collaboration between clinicians and settings of care. Payments that are aligned across clinicians, settings, and payers may also improve incentives to deliver whole-person care that meets both physical and mental health needs. This chapter reviews challenges in access to behavioral health care, coordination of care, and integration of behavioral health care within primary care and other health care settings.

*Access to Care and Treatment.* Among individuals who need behavioral health care, the median time from symptom onset to first treatment is 11 years.<sup>1</sup> Multiple factors may contribute to this gap, including workforce shortages, relatively low behavioral health provider network participation rates, and gaps or limits on Medicare and Medicaid coverage, among other potential drivers. In 2016, only 6% of SUD treatment facilities offered all three medications for OUD approved by the Food and Drug Administration.<sup>2</sup> Current law limits the prescription of methadone to OTPs, which are primarily located in urban areas, limiting access in rural areas.<sup>3</sup> Buprenorphine access is also limited, as providers must obtain an X-waiver to prescribe this medication, which limits the number of providers available to provide patients with life-saving treatment.

*Care Coordination.* Lack of care coordination limits the ability of Americans with behavioral health needs to get the right the care at the right time. On average, Medicare beneficiaries have three primary care visits and five specialist visits every year.<sup>4</sup> Individuals with chronic conditions, including behavioral health conditions, can see even more clinicians across multiple settings of care, making care coordination an even greater challenge for people with behavioral health conditions. For example, follow-up rates with a mental health clinician after a hospitalization are often poor.<sup>5</sup> Care managers and care coordinators can help manage some of these situations, but breakdowns are still common and critical information, such as patient care plans, are often not transferred with patients as they transition through the health care system.<sup>6</sup>

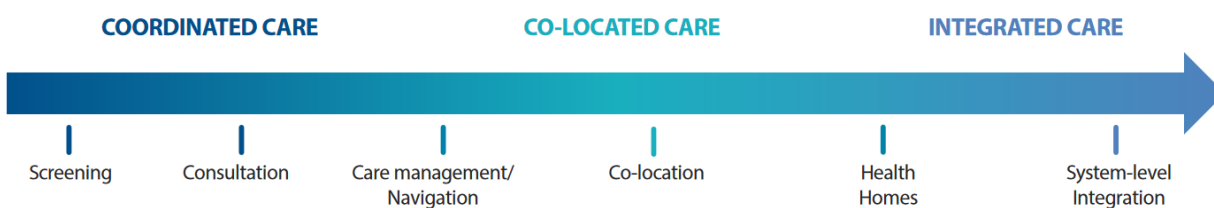
Electronic Health Records (EHR) can facilitate communication when patients move between care settings. However, behavioral health providers have adopted EHRs at a much lower rates than their medical counterparts.<sup>7</sup> Experts have pointed to a number of challenges that has slowed health IT adoption.<sup>8</sup>

### Key Facts:

- Access to the right behavioral health care at the right time is lacking for too many Americans, with the median time between onset of a patient's symptoms and their first treatment spanning 11 years.
- Better access to care requires not only access to clinicians, but also information exchange and collaboration between clinicians and settings of care.
- Care coordination breakdowns are still common and critical information, such as patient care plans, are often not transferred with patients as they transition through the health care system.
- Take-up rate for innovative, evidence-based integration models remains low among health care providers due to a variety of factors, including resources and system changes needed to stand up the models.

*Crisis Services.* Effective care coordination and access to services is also essential to support individuals who experience mental health or SUD related crises. Helping individuals in crisis connect with care appropriate to their needs can prevent conditions from escalating further, helping to avoid unnecessary hospitalization or incarceration. Such crisis intervention services exist along a care continuum, ranging from, for example, crisis call and text lines, mobile crisis teams that respond directly in communities, and crisis stabilization centers. Individuals in crisis also turn to hospital emergency rooms to access urgent care. Over the past decade, emergency room visits for mental health or SUD concerns have increased, particularly in the wake of the COVID-19 pandemic.<sup>9</sup> Reports have described how this demand has increasingly led hospitals to board patients, particularly children, in emergency departments for days and sometimes weeks before they can connect patients to appropriate care.<sup>10</sup> Attention is urgently needed to improve access to care for these individuals.

Figure 1: Continuum of Physical and Behavioral Health Care Integration (Source: Center for Health Care Strategies, Inc. 2019)



*Behavioral health Integration:* Behavioral health care integration refers to any situation in which behavioral health services and physical health services are provided or financed in a cooperative manner. When integrated, behavioral and physical health providers act as a team and proactively communicate to solve problems. A range of integration of behavioral and physical health care can occur – see Figure 1. Providing or financing behavioral health with primary care has been found to improve outcomes for patients with chronic medical illness and depression, as well as to increase quality of care, improve health, and reduce spending.<sup>11,12</sup> Integrated primary and behavioral health care has also been found to improve outcomes for patients with SMI.<sup>13</sup> Similarly, community-based mental health services such as Assertive Community Treatment and Intensive Case Management have been found, in some cases, to effectively manage physical health conditions.<sup>14,15</sup> Intergration of SUD treatment in health care systems is associated with reduced substance use and improved mortality.<sup>16,17</sup> Despite evidence of better outcomes, however, billing for collaborative care management of behavioral health by primary care physicians in the Medicare program has remained relatively low. Uptake is slowed by the complexity of the billing and coding requirements under Medicare, as well as a shortage of behavioral health practitioners, and the need for improved training for staff and physicians to deliver integrated physical and behavioral health care.<sup>18</sup>

*Integrating Care for Dual Eligibles:* Over 12 million people are dually eligible for the Medicare and Medicaid programs. Individuals who are dually eligible include those under 65 who have disabilities and individuals over 65. It is estimated that nearly one-third of dually eligible individuals are living with SMI.<sup>19</sup> Dually eligible individuals account for 20% of Medicare enrollment, but 25% of Medicare spending. In Medicaid, dual eligible individuals account for 15% of enrollment but 32% of spending.<sup>20</sup> Medicare and Medicaid coverage together cover a broad range of health care services, but the two programs are not designed to coordinate. To address this, states and the Medicare program have been



testing integrated care models to improve care delivery and reduce unnecessary health care spending. Only 10% of dual eligible are enrolled in an integrated care model.<sup>21</sup>

*Future Direction:* The Committee received 263 responses to the RFI regarding behavioral health integration, coordination, and access to care. Commenters suggested policies to expand Medicare funding for care navigators, expand peer support specialists and crisis intervention models, and support EHR uptake and interoperability. A number of RFI submissions raised the Collaborative Care Model, Certified Community Behavioral Health Clinics, general support for telehealth and cross-state licensure flexibilities as tools to increase access to care, and the potential need for co-location of services or more engaged case management. Also mentioned was the importance of better integration and coordination of disparate grant funding sources.

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## Chapter 6. Mental Health and SUD Parity

For many years, health insurers were allowed to place annual and lifetime limits on behavioral health services and greater limits and scrutiny on behavioral health services compared to medical or surgical services. Mental health/SUD parity laws have since prohibited these practices by most commercial and employer self-insured health plans, yet federal reports show parity gaps persist.<sup>1</sup> This chapter summarizes the legislative history of mental health parity laws, parity enforcement, and potential challenges or gaps in coverage in the Medicare, Medicaid, and CHIP programs.

*Legislative History.* Congress has passed several laws addressing parity of mental health and SUD coverage in private insurance, Medicaid, CHIP, and Medicare (a comprehensive list prepared by the Congressional Research Service can be found in Appendix B).

- 1996: *Mental Health Parity Act* eliminated annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits among large group health plans.
- 2008: *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act* (MHPAEA) required group health plans and self-insured plans with more than 50 workers to cover behavioral health services on par with medical and surgical services.
- 2008: *Medicare Improvements for Patients and Providers Act* phased-in parity in cost-sharing for Medicare coverage of outpatient mental health services.
- 2010: *Patient Protection and Affordable Care Act* (ACA) expanded the applicability of MHPAEA to individual market plans and certain small group market plans, as well as Medicaid alternative benefit plans (ABPs).
- 2018: *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act* required states with separate CHIP programs that provide MH or SUD benefits to comply with MHPAEA parity requirements, and expanded MH/SUD telehealth services in Medicare.
- 2020: *Consolidated Appropriations Act, 2021* requires group health plans and health insurance issuers to perform and document comparative analyses of nonquantitative treatment limitations (NQTLs) for MH/SUD benefits, and deemed Medicaid MCOs, Medicaid ABPs coverage and CHIP to be in compliance with this requirement if they meet applicable parity requirements in Medicaid and CHIP regulations.

*Medicare, Medicaid, and CHIP.* Federal parity requirements do not apply uniformly to federal health programs. Federal parity requirements apply to Medicaid managed care plans and, regardless of the

### Key Facts:

- Since 1996, Congress has enacted multiple laws addressing mental health and SUD parity, but there is insufficient compliance data.
- Medicare does not cover services from all mental health and SUD providers and imposes lifetime limits on coverage for care received in inpatient psychiatric facilities.
- Health plans often have fewer behavioral health providers in-network compared to other providers, contributing to barriers to finding affordable care.

delivery system, alternative benefit plans and CHIP.<sup>2</sup> State Medicaid plan services delivered through fee-for-service are generally not subject to federal parity rules. Federal parity requirements also do not apply to Medicare fee for service, but do apply to one type of Medicare Advantage plans: Special Needs Plans.<sup>3,4</sup> Medicare coverage policies for Part A covered medical and behavioral services would not meet the parity standards for commercial insurers: there is a 190-day lifetime limit on inpatient psychiatric facility stays that does not exist for inpatient care in other settings. In addition, Medicare excludes certain behavioral health providers, such as licensed professional counselors and marriage and family therapists, from the program and only covers partial hospitalization services in limited situations.<sup>5,6</sup>

*Parity Enforcement.* In a 2022 report to Congress, the Departments of Labor, Health and Human Services, and Treasury reported numerous mental health parity violations including unequal treatment limitations, prior authorization requirements, and treatment exclusions.<sup>7</sup> A 2020 GAO report noted that the full extent of non-compliance with the mental health parity law is not known because many consumers may not know about the requirements of the law.<sup>8</sup> While the Treasury Department has authority to levy an excise tax on non-compliant health plans, the GAO noted that Department of Labor has never referred a noncompliant employer-sponsored health plan to Treasury.

*Network Adequacy.* A number of RFI commenters noted that finding in-network behavioral health providers is a challenge and often a barrier to accessing care. Studies of individual market plans and Medicare Advantage have found that networks cover a smaller proportion of behavioral health providers than of primary care providers.<sup>9,10</sup> Numerous commenters point to low health plan reimbursement rates as one reason for limited network participation in commercial health plans<sup>11</sup> and Medicare Advantage.<sup>12</sup> In addition, federal reports have found health plan provider directories to be often inaccurate.<sup>13,14</sup> Without adequate in-network access, patients are more likely go out of network for behavioral health services.<sup>15</sup> Although MHPAEA applies to the standards and processes commercial insurers use to build their provider networks, the implementation of these standards has been difficult to monitor and assess.

*Underserved Areas.* Access to care in rural and urban underserved areas is directly impacted by the workforce shortages discussed in Chapter 3. In addition, coverage and payment policies under Medicare and Medicaid programs may contribute to care or access barriers because these programs do not have to include the full range of clinicians or clinical care options.<sup>16,17</sup>

*Racial and Ethnic Health Disparities.* Limitations in Medicare and Medicaid coverage and payment policies may contribute to access to care barriers among racial and ethnic minorities. Black, Hispanic, American Indian/Alaskan Native, and Native Hawaiians and Other Pacific Islander nonelderly adults are more likely to have Medicaid or other public coverage compared to White nonelderly adults.<sup>18</sup>

*Future Direction.* The Committee received 177 responses to the RFI addressing parity. Of the responses submitted, suggestions range from extending MHPAEA parity requirements to all forms of coverage under Medicaid, CHIP, and Medicare. Commenters also suggested increasing oversight and enforcement of parity laws, and clarifying existing guidance regarding non-quantitative treatment limits.

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## Chapter 7. The Role of Telehealth

Telehealth enables patients and providers to connect with one another in multiple settings, including at home, in a clinic, or in a community facility. In response to the COVID-19 pandemic, many health care providers shifted their in-person practices to telehealth modalities.<sup>1</sup> This chapter defines telehealth services and summarizes the evidence on barriers to tele-behavioral health care, effectiveness, and the challenges facing those living in rural areas and racial and ethnic minorities.

*Telehealth Defined.* Telehealth is an umbrella term used to describe the various different modalities that can be used to deliver health care services remotely, such as a patient and provider connecting via video call, over the phone, or through the exchange of electronic records. Synchronous forms of telehealth involve a live interaction between a patient and provider via phone or video and are typically used for clinical assessment, continuing care and treatment, or providing emergency triage services. Asynchronous forms of telehealth (or “store-and-forward”) involve the sharing of health information via messaging, web portals or electronic medical records.<sup>2</sup> Patients can access behavioral health care services, such as psychotherapy, counseling, substance use treatment, and suicide intervention via telehealth.

*Telehealth Research.* Studies have found that telehealth services for behavioral health care can be equivalent to in-person care in certain circumstances,<sup>3</sup> and in certain contexts, there can be little difference between face-to-face (in-person or video) and audio-only behavioral health services.<sup>4</sup> Several studies have shown high rates of patient satisfaction with tele-behavioral health care services.<sup>5</sup> Some commenters noted that audio-only telehealth services limit a clinician’s ability to observe certain physical behaviors, and recommended that combination of audio, audio-visual, and in-person services may be appropriate for certain types of patients. RFI commenters noted that the telehealth modality may reduce barriers to behavioral health care<sup>6</sup> because it could reduce stigma associated with accessing mental health and SUD services, difficulties attending appointments due to issues with transportation or child care,<sup>7</sup> and geographical barriers that prevent patients from seeking a provider. RFI comments also noted that state licensure laws sometimes limit access to tele-behavioral health care.

*COVID-19 Impacts.* The COVID-19 pandemic required the health care system to quickly adapt, including making a pivot away from delivering health care services in traditional clinical settings. For example, Medicare visits conducted through telehealth increased 63-fold, from 840,000 visits in 2019 to 52.7 million visits in 2020.<sup>8</sup> In addition, among Medicare beneficiaries, one-third of telehealth visits were for

### Key Facts:

- Tele-behavioral health may increase access to behavioral health care by reducing stigma associated with accessing mental health and SUD services and difficulties attending appointments due to issues with transportation or child care.
- Use of tele-behavioral health services proved to be vital during the COVID-19 pandemic, and Congress built on that success in 2020 by permanently removing many Medicare barriers to tele-mental health.
- More work is needed to continue to eliminate impediments to tele-behavioral health and innovative technologies.

behavioral health care providers, the highest utilization rate in comparison to other health care providers in 2020.<sup>9</sup> Other studies of provider organizations' administrative data found similar trends.<sup>10</sup> Federal and state policymakers also made significant alterations to allow more flexible behavioral health treatment guidelines during the COVID-19 pandemic, including allowing the initiation of medication for OUD via telemedicine and waiving in-person visit requirements, which can create access challenges in rural areas.<sup>11,12</sup> State Medicaid programs also significantly expanded their telehealth flexibilities through state plan amendments and waivers during the public health emergency.

*Medicare and Medicaid Coverage.* Prior to the COVID-19 PHE, Medicare paid for a limited number of telehealth services only if they were provided to beneficiaries who were located in a qualified "originating site," such as a clinician's office or a hospital, located in a rural area. The beneficiary's home is not normally considered an originating site. For certain services, Congress has established several exceptions to allow for telehealth to be delivered to beneficiaries regardless of urban or rural location and in their homes. The *Consolidated Appropriations Act, 2021 (CAA)* created such an exception for certain mental health services,<sup>13</sup> while the *SUPPORT for Patients and Communities Act* created an exception for certain SUD services. However, the CAA requires an initial in-person visit prior to the initiation of tele-mental health services. Separate from these permanent changes, during the PHE, HHS and CMS have temporarily waived the geographic and originating site restrictions for all covered telehealth services, so that urban and rural patients can receive telehealth in their home. All state Medicaid programs provided similar flexibilities. CMS also established coverage for audio-only forms of telehealth during the COVID-19 PHE. For many mental health and SUD services, CMS has recently established permanent coverage for audio-only visits.

*Underserved Access.* Despite challenges with access to broadband internet,<sup>14</sup> smart phones and computers,<sup>15</sup> telehealth utilization has grown in rural and urban areas.<sup>16</sup> From 2010 to 2017, telehealth visits for mental health increased by 425% among rural Medicare beneficiaries.<sup>17</sup> Between 2016 and 2019, treatment for SUD via telehealth increased from 13.5% to 17.4%, with a greater adoption being associated with rural locations.<sup>18</sup> Under the PHE, Medicare telehealth utilization increased sharply at the start of the COVID-19 pandemic in both urban and rural areas, and despite declining somewhat in the latter half of 2020, utilization has remained substantially higher than 2019 levels.<sup>19</sup>

*Racial and Ethnic Health Disparities.* Evidence on the extent of racial and ethnic differences in telehealth use is still emerging. While some studies have found lower use, interest, or trust in telehealth among Black patients<sup>20,21</sup> others have found the opposite<sup>22</sup> or no relationship.<sup>23</sup> Similarly, relationships among Hispanic and Asian patients are not well understood. There are likely confounding factors such as income, access to internet, access to a smartphone, and age that also contribute to differences in telehealth usage.<sup>24</sup>

*Future Direction.* The Committee received 217 responses to the RFI addressing telehealth. A number of responses eliminating the CAA's in-person visit requirement for tele-mental health services. Several stakeholders also supported continued reimbursement for audio-only telehealth services for the diagnosis and treatment of mental health and SUD conditions.

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## Chapter 8. Next Steps

The Committee's fact-finding efforts have revealed that, overwhelmingly, access to affordable, reliable, and high-quality behavioral health care escapes Americans when they need it the most. Stigma around behavioral health care remains pervasive and rates of SUD and suicide are rising. Racial and ethnic minorities and people living in urban and rural underserved areas are less likely to receive care. Mental health outcomes and challenges have worsened over the past several years and have been exacerbated further by the COVID-19 pandemic.

As this report describes, the behavioral health challenges and barriers facing millions of Americans are complex and multi-faceted. Addressing these challenges will require a range of policy solutions that span Medicare, Medicaid, and CHIP, from expanding the workforce to addressing parity in federal programs and more.

In our pursuit to understand and address the complexities of the behavioral health crisis, it is important to keep in mind the very real consequences of inaction. Lack of access to mental health or SUD treatment can be a life or death issue. It can mean years or sometimes a lifetime of illness holding people back from being fully present for their families and friends. Over 50 million Americans has a mental health condition; over 40 million people have a SUD; and 17 million people are living with both a mental health condition and SUD. There is an undeniable and urgent need to address these issues. Millions of Americans, including their family members and friends, are counting on us.

## Appendix A.

### Senate Committee on Finance Hearings on Behavioral Health in the 117th Congress

Date	Title	Witnesses
May 12, 2021	The COVID-19 Pandemic and Beyond: Improving Mental Health and Addiction Services in Our Communities (Subcommittee on Health)	Victor R. Armstrong, MSW, North Carolina Department of Health and Human Services Stephanie Woodard, PsyD, Nevada Department of Health and Human Services Lenette Kosovich, RN, MHA, Rimrock Foundation Malkia Newman, CNS Healthcare Anti-Stigma Program
May 19, 2021	COVID-19 Health Care Flexibilities: Perspectives, Experiences, and Lessons Learned	Jessica Farb, US Government Accountability Office Kisha Davis, MD, MPH, American Academy of Family Physicians Linda V. DeCherrie, MD, Mount Sinai Health System Narayana Murali, MD, Marshfield Clinic Robert A. Berenson, MD, Urban Institute
June 15, 2021	Mental Health Care in America: Addressing Root Causes and Identifying Policy Solutions	Benjamin F. Miller, PsyD, Well Being Trust Chantay D. Jett, MA, Wallowa Valley Center for Wellness Michelle P. Durham, MD, MPH, FAPA, DFAACAP, Boston Medical Center Thomas Betlach, MPA, Speire Healthcare Strategies
February 8, 2022	Protecting Youth Mental Health: Part I - An Advisory and Call to Action	The Honorable Vivek H. Murthy, M.D., M.B.A., Surgeon General, Office of the Secretary US Department of Health and Human Services
February 15, 2022	Protecting Youth Mental Health: Part II - Identifying and Addressing Barriers to Care	Tami D. Benton, MD, FAACAP, FAAP, Children’s Hospital of Philadelphia Sharon Hoover, PhD, University of Maryland School of Medicine Jodie L. Lubarsky, MA, LCMHC, Seacoast Mental Health Center Trace Terrell, YouthLine



## Appendix B.

### Timeline of Federal Mental Health and SUD Parity Laws

Brief summary of major laws related to mental health and SUD parity since the Mental Health Parity Act of 1996 prepared by the Congressional Research Service.

Year	Public Law	Legislation
1996	P.L. 104-204, Title VII	The <b>Mental Health Parity Act of 1996</b> (MHPA) amended the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act (ERISA) to add parallel mental health (MH) parity provisions to both Acts. PHSA §2705 <sup>1</sup> and ERISA §712, as added by the MHPA, applied parity to fully- and self-insured large group health plans—if they offered MH benefits and medical/surgical benefits—in the areas of aggregate lifetime and annual dollar limits. The MHPA excluded substance use disorder (SUD) treatment from the definition of MH benefits subject to the parity requirements. It exempted small employer plans and plans for which implementing parity would result in increased operating costs above specified thresholds. The provisions were set to expire on September 30, 2001. <sup>2</sup>
1997	P.L. 105-33 (§4704 and §4901)	The <b>Balanced Budget Act of 1997</b> amended the Social Security Act (SSA) to require Medicaid managed care organizations and coverage under the State Children’s Health Insurance Program (CHIP) to comply with certain private health insurance requirements, including MH parity, by reference to the PHSA.
	1997 P.L. 105-34 (§1531)	The <b>Taxpayer Relief Act of 1997</b> added MH parity language to the Internal Revenue Code (IRC). New IRC §9812 MH parity language was parallel to the language in PHSA §2705 and ERISA §712.
2002	P.L. 107-116 (§701)	The <b>Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act</b> amended the PHSA, ERISA, and IRC to extend MH parity provisions through December 31, 2002.
	P.L. 107-147 (§610)	The <b>Job Creation and Worker Assistance Act of 2002</b> amended the IRC to extend MH parity provisions through December 31, 2003. <sup>3</sup>
	P.L. 107-313	The <b>Mental Health Parity Reauthorization Act of 2002</b> amended the PHSA and ERISA to extend MH parity provisions through December 31, 2003.
2003	P.L. 108-197	The <b>Mental Health Parity Reauthorization Act of 2003</b> amended the PHSA and ERISA to extend MH parity provisions through December 31, 2004.

<sup>1</sup> In 2010, The Patient Protection and Affordable Care Act (P.L. 111-148) redesignated PHSA §2705 as PHSA §2726.

<sup>2</sup> Mental health parity is codified in three parts of federal statute: (1) the Public Health Service Act (PHSA) which generally relates to health insurance; (2) the Employee Retirement Income Security Act (ERISA) which relates to employer-sponsored health insurance; and (3) the Internal Revenue Code (IRC) which relates to taxes on health insurance premiums.

<sup>3</sup> Section 610 of P.L. 107-147 also amended IRC Section 9812 so that parity would not apply to benefits for services furnished between September 30, 2001, and January 10, 2002.

2004	P.L. 108-311 (§302)	The <b>Working Families Tax Relief Act of 2004</b> amended the PHSA, ERISA, and IRC to extend MH parity provisions through December 31, 2005. <sup>4</sup>
2005	P.L. 109-151	P.L. 109-151 (no official title) amended the PHSA, ERISA, and IRC to extend MH parity provisions through December 31, 2006.
2006	P.L. 109-432 (§115)	The <b>Tax Relief and Health Care Act of 2006</b> amended the PHSA, ERISA, and IRC to extend MH parity provisions through December 31, 2007.
2008	P.L. 110-245 (§401)	The <b>Heroes Earnings Assistance and Relief Tax Act of 2008</b> amended the PHSA, ERISA, and IRC to extend MH parity provisions through December 31, 2008. <sup>5</sup>
	P.L. 110-275 (§102)	The <b>Medicare Improvement for Patients and Providers Act of 2008</b> authorized under Medicare a 5-year transition period to establish payment equity for covered outpatient expenses incurred in a calendar year in connection with the treatment of mental health disorders.
	P.L. 110-343, Division C, Title V, Subtitle B (§§511-512)	The <b>Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008</b> amended the PHSA, ERISA, and IRC to expand parity provisions to SUD benefits; apply MH/SUD parity protections to financial requirements and treatment limitations and to applicable benefits provided out-of-network (in addition to aggregate lifetime and annual dollar limits); and add transparency standards requiring private health insurance plans and issuers to make available upon request the criteria for medical necessity determinations and the reasons for denial of payments. MHPAEA preserved but amended the exemptions for small employer plans and plans for which implementing parity would result in increased operating costs above specified thresholds. It added new requirements for the Secretaries of Health and Human Services (HHS), Labor, and the Treasury (the Tri-Agencies) to submit reports to Congress as specified, and to publish guidance on MH parity requirements for plans, issuers, and other stakeholders. It also required Government Accountability Office (GAO) reports to Congress as specified. The law did not include sunset dates. (These new provisions of the PHSA continued to apply to Medicaid MCOs and to CHIP as required by the Balanced Budget Act of 1997.)
	P.L. 110-460	P.L. 110-460 (no short title) made a technical correction to MHPAEA. <sup>6</sup>
2009	P.L. 111-3 (§502)	The <b>Children's Health Insurance Program Reauthorization Act of 2009</b> amended §2103(c) of the SSA to apply certain MHPAEA requirements to CHIP by reference to the PHSA. Specifically, it applied MH/SUD parity provisions in the areas of aggregate lifetime and annual dollar limits (if any) to separate CHIP plans that offer MH/SUD benefits and medical/surgical benefit. It also

<sup>4</sup> Section 302 of P.L. 108-311 also amended IRC Section 9812 so that parity would not apply to benefits for services furnished between January 1, 2004, and October 4, 2004 (the date of enactment).

<sup>5</sup> Section 401 of P.L. 110-343 also amended IRC Section 9812, ERISA Section 712, and PHSA Section 2705 (as it was then numbered) so that parity would not apply to benefits for services furnished between January 1, 2008, and June 6, 2008 (the date of enactment).

<sup>6</sup> P.L. 110-460 changed a date from January 1, 2009, to January 1, 2010.

		deemed CHIP plans that include coverage of early and periodic screening, diagnostic, and treatment (EPSDT) services to be compliant with MHPAEA. <sup>7</sup>
2010	P.L. 111-148 (§§1201, 1302, 1311, 1563, and 2001)	<p>The <b>Patient Protection and Affordable Care Act of 2010</b>, as amended, included private health insurance provisions that expanded the applicability of MHPAEA to individual market plans and certain small group market plans. Specifically, §1563(c)(4) (as renumbered) amended MHPAEA to apply to plans sold in the individual market, regardless of grandfathered status. Section 1311(j) specified that qualified health plans (QHPs), which are plans certified to be sold in the individual and small group exchanges, are subject to MHPAEA.</p> <p>Sections 1201 and 1302 also required nongrandfathered individual and small group plans to cover certain essential health benefits (EHB), including “mental health and substance use disorder services.” (The Tri-Agencies confirmed through rulemaking that these EHB requirements meant that non-grandfathered, fully-insured small group plans must cover the EHB and therefore must comply with MH parity requirements.)</p> <p>Section 2001(c) extended MH parity requirements to Medicaid alternative benefit plans (ABPs). Specifically, if coverage under an ABP included both medical and surgical benefits and MH or SUD benefits, then the financial requirements and treatment limitations that apply to the MH and SUD benefits must comply with the MH parity requirements described in the PHSA. Section 2001(c) provided that Medicaid ABPs offering EPSDT services shall be deemed compliant with MHPAEA requirements for beneficiaries entitled to EPSDT benefits.</p>
2016	P.L. 114-255, Division B, Title XIII (§§13001-13007)	<p>The <b>Helping Families in Mental Health Crisis Reform Act of 2016</b> included MH parity provisions primarily focused on private health insurance MHPAEA compliance. For example, it amended MHPAEA (at PHSA §2726) to require the Tri-Agencies to issue a “compliance program guidance document.” It also required the Tri-Agencies to submit reports on parity investigations to specified congressional committees, and it required a GAO study on MHPAEA compliance. It also applied MHPAEA requirements to eating disorder benefits provided by plans and issuers subject to MHPAEA. That is, if such a plan or issuer provides coverage of eating disorder benefits, including residential treatment, it must do so consistent with MHPAEA requirements.<sup>8</sup></p>
2018	P.L. 115-271 (§§7182, 5022, and 2001)	<p>The <b>Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT)</b> for Patients and Communities Act expanded the requirements of the annual MH parity compliance reports to Congress. Section 7182 required the annual reports to include investigations of parity compliance generally (replacing “serious violations”) and added a summary of</p>

<sup>7</sup> Early and periodic screening, diagnostic, and treatment (EPSDT), the broad Medicaid pediatric benefit, encompasses periodic screenings, certain interperiodic screenings, diagnosis, and treatment including physical, mental, vision, hearing, and dental services, among others. For more information on EPSDT, see 42 C.F.R. Part 441, Subpart B; Centers for Medicare and Medicaid Services (CMS), EPSDT: A Guide for States, June 2014, at [https://www.medicare.gov/medicaid/benefits/downloads/epsdt\\_coverage\\_guide.pdf](https://www.medicare.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf).

<sup>8</sup> For more information, see CRS Report R44718, The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255).

		coordination between specified agencies, among other things. Section 5022(d) required states with separate CHIP programs that provide MH or SUD benefits to comply with MHPAEA parity requirements. Section 2001 expanded MH/SUD telehealth services in Medicare by eliminating certain geographic originating site restrictions. <sup>9</sup>
2020	P.L. 116-260, Division BB, Title II (§203) and Division CC, Title I (§123)	The <b>Consolidated Appropriations Act, 2021</b> requires group health plans and health insurance issuers to perform and document comparative analyses of nonquantitative treatment limitations (NQTLs) for MH/SUD benefits and medical and surgical benefits. The provision required the Tri-Agencies to request and review at least 20 comparative analyses from applicable plans and issuers that may involve a violation or a complaint regarding noncompliance with mental health parity requirements. The information in the comparative analyses is to be used to determine compliance, as well as develop guidance to help group health plans and health insurance issuers comply with MH parity requirements. The Tri-Agencies must also annually submit reports to Congress, and share information with relevant states and the public, as specified. Section 203 deemed Medicaid MCOs, Medicaid ABP coverage and CHIP to be in compliance with this requirement if they already meet the terms of parity requirements in Medicaid and CHIP regulations. Section 123 expanded MH/SUD telehealth applicability in Medicare.

Notes: ABPs=Alternative Benefit Plans; CHIP=Children’s Health Insurance Program; EHB=Essential Health Benefits; EPSDT=Early and periodic screening, diagnostic, and treatment; ERISA= Employee Retirement Income Security Act; GAO=Government Accountability Office; IRC=Internal Revenue Code; MCOs=Managed Care Organizations; MH=Mental health; MHPA=Mental Health Parity Act of 1996; NQTLs=Nonquantitative treatment limitations; PHSA=Public Health Service Act; SSA=Social Security Act; SUD=Substance use disorder; Tri-agencies=Departments of HHS, Labor, and the Treasury.

<sup>9</sup> For more information, see CRS Report R45423, Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act.