Statement for the United States Senate
Committee on Health, Education, Labor and Pensions

April 28, 2021

Examining Our COVID-19 Response: Using Lessons Learned to Address Mental Health and Substance Use Disorders

Submitted by
National Association of Health Underwriters

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer and utilize health plans of all types. These plans include coverage for mental and behavioral health benefits as is required by law. We are pleased to have the opportunity to submit recommendations to the subcommittee in regards to improving access to behavioral and mental healthcare. These recommendations were put together with the help of NAHU's Mental Health Task Force, a legislative working group made up of NAHU members who are health insurance and employee benefit professionals with an advanced understanding of mental and behavioral health services and how they are provided and used in health plans.

Access to mental health services is a crucial component of healthcare. National discussion has addressed mental health care for years, but often focuses more on physical health. The COVID-19 pandemic has reminded us of the importance of adequate mental health care and exposed a mental health crisis: About 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019[1]. For these reasons it is more vital than ever that consumers are able to access and afford behavioral health services.

Continuity of Care

The Mental Health Parity and Addiction Equity Act of 2008 created standards for the financial requirements and treatment limitations that a group health plan or group health plan issuer may impose on mental health and substance use disorder (MHSUD) benefits. MHPAEA established that financial requirements (such as copayments, coinsurance) and treatment limitations (such as limits on the number of outpatient visits, or prior authorization requirements) cannot be more restrictive than those that apply to medical and surgical benefits. With regard to financial requirements or quantitative treatment limitations (such as the number of inpatient days covered), a plan cannot impose a requirement or limitation on MHSUD benefits that is more restrictive than what is imposed on two-thirds of the medical and surgical benefits in the same classification. While this legislation made great strides in improving access and affordability, more must be done to improve continuity of care and network adequacy in the behavioral health space.

One major example of an improper break in continuity of care occurs during the appeals process when a claim for mental or behavioral health service is denied. The family, or responsible party, of a patient must sign a financial agreement that makes them liable for the full cost of care during the grievance process if the individual is to remain in treatment while appeals are completed, imposing undue financial and emotional duress.

Currently the time allowed for appeal of a denial of payment for Mental Health Services is 30 days, the same length of time for medical and surgical appeals. For mental health patients, this gap in treatment can lead to the loss or reversal of clinical gains. For some patients this can include life-threatening consequences, readmissions and the potential waste of

[1] March 15, 2021. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic. *Kaiser Family Foundation.* https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

initial investment in treatment. Ultimately, this gap caused by a long appeal process has an immensely harmful impact on the patient and their family or caregiver, emotionally and financially. For these reasons, NAHU recommends requiring all appeals of denials and grievances for MHSUD to automatically be escalated to urgent status. Urgent status usually allows a review time of significantly less than 30 days and will ensure that these appeals are expedited leveraging an existing method.

Network Adequacy

Another way in which Congress can improve Americans' access to mental and behavioral health services is by addressing network adequacy. Network adequacy has been an issue in the mental and behavioral health service sphere for quite some time. While attempts have been made to make improvements in this area, there is still a significant amount of ground to cover. 119.3 million Americans live in areas designated as "Mental Health Professional Shortage Areas." [2] Often it is difficult for patient to locate a provider that accepts insurance at all, much less participates in their insurer's network. If a provider does participate, that participation may not be consistent resulting in provider directory inadequacy. A survey of privately insured patients found that 53 percent of those that used provider directories found inaccuracies in their insurer's provider directory, often leading them to receive care from out-of-network providers.[3]

NAHU recommends that Congress consider incentives to encourage providers to participate in network plans including plans that use mental health carve-outs, as well as increase incentives for plans with mental health carve-outs to contract with willing MHSUD providers, possibly by increasing the percentage of the Medicare rate at which they are reimbursed. We also recommend increasing incentives for carriers with mental health carve-out plans to expedite the contracting process, and prioritize updating provider lists. The contract negotiation process between carriers and providers is a source of inefficiency, as the process can take a significant amount of time and can add yet another barrier to receiving care.

Collaborative Care Model

One glaring cause of inefficiency impeding Americans' access to mental and behavioral health is the lack of communication between behavioral health and primary care providers. Since mental and behavioral health is often not integrated with primary care, this leaves patients with undiagnosed or poorly managed mental and behavioral health conditions, despite the fact that mental and behavioral health conditions often initially appear in a primary care setting.

Currently, primary care clinicians provide mental health and substance use care to the majority of people with mental and behavioral disorders and prescribe the majority of psychotropic medications. NAHU believes that a collaborative care model that incorporates behavioral health and primary care could significantly decrease the weight of other illness,

[2] September 30, 2020. Mental Health Care Health Professional Shortage Areas (HPSAs). *Kaiser Family Foundation*. https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] Busch, S. & Kyanko, K. June 2020. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs*. Retrieved February 1, 2020 at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.

lessen the demand for mental and behavioral health services, and thereby lower medical costs and reduce disparities in identification and the effectiveness of treatment for behavioral health issues.

Telehealth

Because of the pandemic, rules related to all aspects of telehealth, including tele-behavioral health (TBH), have been loosened. This has resulted in immense increase in the use of tele-behavioral health services, enabling cross-state care which has been critical to underserved areas and rural communities. TBH has the potential to overcome patient stigma and improve access and efficiency of care for mental and behavioral health services. In general, when patients keep their first appointment, they are more likely to keep subsequent appointments; and when patients are satisfied with treatment, they are more likely to continue with their course of therapy which could lead in a decrease in cost for treatment of an individual over the course of their care.

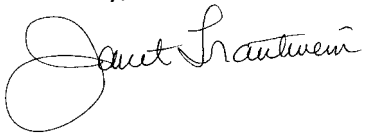
Unfortunately, many older adults and people with disabilities, lack access to video-enabled devices or struggle to use the more complex video-enabled devices even if they have them. Likewise, many in ethnic and low- income communities lack access to broadband or video-enabled devices, which only expands the health inequities in the U.S. Due to this, NAHU recommends eliminating cross-state border restrictions on tele-behavioral health, permanently, as well as adopting technology-neutral requirements, permitting use of different types of technology platforms that are designed for telehealth.

Mental Health Parity

Fully insured and self-funded ERISA plan sponsors are required to comply with the quantitative treatment limits imposed by the Mental Health Parity Act. However, fully insured and ERISA plan sponsors have no control over the non-quantitative treatment limits associated with Mental Health parity laws since they rely on their intermediaries such as third party administrators to monitor and comply with network adequacy requirements for access to mental and behavioral health care. There have been several lawsuits related to the non-quantitative treatment limits of mental health parity laws. NAHU recommends that the federal government create a safe harbor status for fully insured and self-insured ERISA plan sponsors which rely on independent certification of compliance with Mental Health parity requirements as included in the MHPAEA and most recently the Consolidated Appropriations Act of 2021.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



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