Statement for the Senate Committee on Finance

March 30, 2022

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

Submitted by
National Association of Health Underwriters

999 E STREET NW, SUITE 400 • WASHINGTON, DC 20004 • 202-552-5060 • WWW.NAHU.ORG

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing 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. The health insurance agents and brokers that NAHU represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers select health plans that are best for them. These plans include coverage for mental and behavioral health benefits as is required by law. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees[1] and eighty-four percent of people shopping for individual exchange plans found brokers helpful -- the highest rating for any group assisting consumers.[2]

Access to mental health services is a crucial component of healthcare. National discussion has addressed mental healthcare for years, but often focuses more on physical health. The COVID-19 pandemic has reminded us of the importance of adequate mental healthcare 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[3]. For these reasons it is more vital than ever that consumers can access and afford behavioral health services. These recommendations were put together with the help of NAHU's Mental Health Task Force, a legislative working group comprised of NAHU members with an advanced understanding of mental and behavioral health services and how they are provided and used in health plans.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) 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 those 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. Regarding 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

Most recently, the Consolidated Appropriations Act of 2021 mandated that employers offering medical, surgical, and mental health and substance use disorder coverage provide comparative analyses and relevant supporting documentation demonstrating compliance with mental health parity requirements to the Department of Labor upon request. Both fully insured and self-funded ERISA plan sponsors are required to comply with the quantitative treatment limits imposed by the Mental Health Parity Act. Complying with the new CAA mandates and in particular the non-quantitative treatment limits (NQTL) reporting is challenging for many employers, who, because of their size, must rely on their intermediaries such as third-party administrators to monitor and comply with network adequacy requirements

[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013.
[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014.
[3] Kaiser Family Foundation. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic. 27 September 2021.

for access to mental and behavioral healthcare. Smaller plans with fewer compliance resources particularly struggle with the complexity of the MHPAEA rules, but the complexity concerns in this area extend to plans of all sizes. In the event of a Department of Labor request, these employers often will need to work with legal counsel to identify treatment limitations and contact multiple providers to request information necessary to complete comparative analyses. This makes compliance particularly difficult for employers who already face other compliance requirements relating to the plans they sponsor for employees. To assist employers in this regard, NAHU recommends that reporting requirements for ERISA plan sponsors be lessened by reducing the number of notices, as well as allowing disclosures to be made electronically.

Earlier this year, the Department of Labor, Department of Health and Human Services, and Department of the Treasury released the first Annual Report to Congress on the Mental Health Parity and Addiction Equity Act. Out of the 216 NQTL analyses reviewed by DOL and 21 NQTL analyses reviewed by CMS, none were found to meet regulators' expectations.[4] The Report noted that most of the initial findings of noncompliance were due to incomplete comparative analyses, which did not provide the information, analyses, and supporting documentation the Departments anticipated. These findings underscore the difficulties and complexities that employers are facing as they try to meet MHPAEA and CAA obligations, with employers struggling to determine what is necessary to satisfy these requirements.

NAHU also recommends that Congress look at easing certain regulatory burdens to allow employers to create new and innovative mental health benefits for their employees. Employers want their employees to experience the best possible physical and mental health. These healthy employees make the best workers and increase productivity in the workplace. Because each workforce, workplace and community are different and offer different challenges and opportunities, the lack of flexibility in meeting mental health parity requirements can make it difficult and cumbersome for employers to develop comprehensive mental health benefit programs, as there is concern that they could come in conflict with one of the many regulations in this area. NAHU recommends that employers be given greater flexibility to create new mental health benefit programs outside of the current benefits structure. While these benefits programs would still be subject to the ACA, MHPAEA, and other relevant statutes, the establishment of new stand-alone mental health benefit programs separate from group health plans would be of immense value for Americans seeking MHSUD services and could even be expanded to offer access to mental healthcare to employees who aren't eligible for the employer's health plan(s).

Another way in which Congress can improve Americans' access to mental and behavioral health services is by addressing the shortage of MHSUD providers. While attempts have been made to make improvements in this area, there is still a significant amount of ground to cover. 119 million Americans live in areas designated as "Mental Health Professional Shortage Areas." [5] 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

[4] 2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage. January 2022.
[5] Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). 30 September 2020.

directories found inaccuracies in their insurer's provider directory, often leading them to receive care from out-of-network providers.[6] Additionally, recent American Academy of Pediatrics data shows that there are, on average, just 9.75 child psychiatrists per 100,000 children, and child psychiatrists are disproportionately located in larger urban centers; more than two-thirds of U.S. counties don't have even a single child psychiatrist.[7] According to the Health Resources & Services Administration, an additional 6,586 providers would be needed to bridge the gap for consumers living in these shortage areas.[8]

The workforce shortage is not only an issue in the mental and behavioral health sphere. The United States could see an estimated shortage of between 37,800 and 124,000 physicians by 2034, including a shortfall of between 17,800 and 48,000 primary care physicians.[9] Prior to the COVID-19 pandemic, physician shortages were already evident, with 35 percent of voters in 2019 saying they had trouble finding a doctor in the previous two or three years. This was a 10-point jump from when the question was asked in 2015.[10] To enhance Americans' access to mental and behavioral healthcare, strengthening both the mental health and primary care workforce must be a top priority. NAHU supports workforce development and training programs that aim to increase the amount of MHSUD and primary care professionals.

Strengthening the workforce of both mental health and primary care providers is vital, as a further source of inefficiency impeding Americans' access to mental and behavioral health is the lack of communication between behavioral health and primary care providers. Approximately two-thirds of primary care physicians are unable to connect their patients to outpatient mental health services.[11] 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, even though 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 many 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, 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. Collaborative care models such as Direct Primary Care arrangements and employer-run Accountable Care Organizations would also assist in improving collaboration between primary care and behavioral health providers.

State licensure requirements and cross-state-border restrictions also remain some of the largest, most complex barriers within the mental health space as well as the telemedicine space broadly. Due to the COVID-19 pandemic CMS, along

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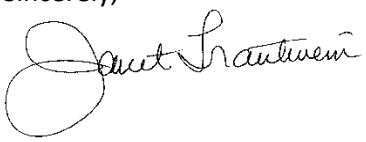
[6] Busch, Susan, et al. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs.* June 2020.
[7] McBain, Ryan, et al. Growth and Distribution of Child Psychiatrists in the United States: 2007–2016. *American Academy of Pediatrics*.
[8] Health Resources and Services Administration. Shortage Areas.
[9] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Association of American Medical Colleges. June 2021.
[10] Ibid
[11] Cunningham, Peter. Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care. *Health Affairs.* 2009

with a handful of states, decided to relax regulations around telehealth and state-licensure requirements, temporarily waiving requirements for licensure in the state where the patient was located. This added flexibility was of great benefit to patients across the country, particularly MHSUD consumers. For these reasons, NAHU recommends that Congress look at ways to facilitate reciprocity of state-provided licenses and other ways to ease cross-state-border restrictions on tele-behavioral health and telehealth generally.

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,



Janet Stokes Trautwein
CEO, National Association of Health Underwriters