National Association of Benefits and Insurance Professionals

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Statement for the Senate Finance Committee

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Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks

Submitted by
National Association of Benefits and Insurance Professionals

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I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly NABIP, a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NABIP 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 NABIP represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that are best for them. 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] During the 2023 open enrollment period, agents and brokers assisted 71 percent of those who enrolled through HealthCare.gov or a private direct enrollment partner's website. Additionally, premiums are 13 percent lower in counties with the greatest concentration of brokers.[3] Consequently, the NABIP membership has a vested interest in ensuring that consumers enjoy affordable health coverage that is the correct fit for their clients.

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. reported symptoms of anxiety or depressive disorder during the pandemic, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019.[4] For these reasons it is more vital than ever that consumers can access and afford mental and behavioral health services.

Unfortunately, a lack of network adequacy has proven a substantial barrier for consumers seeking mental and behavioral health services. While attempts have been made to make improvements in this area, there is still a significant amount of ground to cover. Often it is difficult for patients 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. For example, it is possible that an insurer's in-network provider directory implies a specific plan is accepted by the provider in question, when in reality the provider accepts only certain iterations of the plan (such as the PPO and not the HMO).

Directories that appear accurate only to include providers that are not actually in-network or are not accepting new patients are commonly referred to as "ghost networks." Inaccurate or out-of-date information on which mental health providers are in a health plan's network contributes to ongoing access issues for consumers and often compels consumers to obtain out-of-network care at higher costs. A 2020 survey of privately insured patients found that 53 percent of consumers that used provider

[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] Karaca-Mandic, Pinar, et al. The Role of Agents and Brokers in the Market for Health Insurance. National Bureau of Economic Research. August 2013.
[4] Kaiser Family Foundation. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID-19 Pandemic. 27 September 2021.

directories found inaccuracies in their insurer's provider directory, often leading them to receive care from out-of-network providers.[5] Additionally, the GAO reported in 2022 that the problem of ghost networks in mental healthcare worsened during the pandemic, as providers left their positions or stopped taking new patients due to overload.[6]

With these statistics in mind, it is crucial that Congress address the prevalence of ghost networks and create stronger enforcement standards to protect those seeking mental health services. NABIP believes that the maintenance of reliable network directories should be a shared responsibility between the providers and the insurance carriers, as both entities have the information required to properly preserve the list and prevent networks from becoming ghost networks. However, while the employer is often lumped into regulatory conversations regarding mental health services, it is important to note that they do not have direct control over plan networks and should not be burdened with additional compliance concerns.

The relevant regulatory bodies have already erroneously incumbered employers with mental health parity standards. The Consolidated Appropriations Act of 2021 (CAA) 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 CAA mandates and in particular the non-quantitative treatment limits 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 for access to mental and behavioral healthcare.

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. In 2022, 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 – highlighting the difficulty that employers have in their efforts to comply.[7]

While action must be taken to ensure that carriers' mental health provider directories are accurate, placing the regulatory obligation on employers when they do not have direct control over the directories would be in error and prove as burdensome as mental health parity requirements. Small employers in

[5] Busch, S. & Kyanko, K. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs*. June 2020.
[6] Government Accountability Office. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts. March 2022.
[7] 2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage. January 2022.

particular would struggle to be in compliance with new mental health network adequacy requirements, as they would still rely on third-party administrators to monitor and comply with these network requirements as well. NABIP supports proposals that better enforce mental health network adequacy without needlessly penalizing employers who are working to provide such benefits to their employees.

Mental health services are up to six times more likely than other medical services to be delivered by an out-of-network provider, in part because so many mental health providers do not accept commercial insurance.[8] NABIP 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 mental health providers. 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.

Switching focus from network adequacy to the shortage of mental health providers themselves, 119 million Americans live in areas designated as mental health professional shortage areas – despite the clear need for mental health services across the country.[9] In addition to contributing to challenges consumers face in finding in-network providers, representatives from 17 of the 29 stakeholder organizations that the GAO interviewed in 2022 indicated that workforce shortages have contributed to constraints on overall capacity of the mental health system.[10] Recent American Academy of Pediatrics data also 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.[11] 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.[12]

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.[13] 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.[14] To enhance Americans' access to mental and behavioral healthcare, strengthening both the mental health and primary care workforce must be a top priority. NABIP supports workforce

[8] Busch, S. & Kyanko, K. Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs*. June 2020.
[9] Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). 30 September 2022.
[10] Government Accountability Office. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts. March 2022.
[11] McBain, Ryan, et al. Growth and Distribution of Child Psychiatrists in the United States: 2007–2016. American Academy of Pediatrics. 1 December 2019.
[12] Health Resources & Services Administration. Health Workforce Shortage Areas. 1 May 2023.
[13] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Association of American Medical Colleges. June 2021.
[14] Ibid

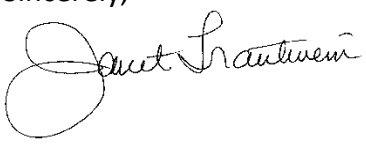
development and training programs that aim to increase the amount of mental health and primary care professionals.

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.[15] 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 most psychotropic medications.

Outside of workforce issues, 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 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 mental healthcare consumers. For these reasons, NABIP 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 NABIP can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nabip.org.

Sincerely,



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[15] Cunningham, Peter. Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care. *Health Affairs*. 2009