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**Testimony of the
American Psychiatric Association**

On

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Submitted for the record to the

U.S. House of Representatives Education and Labor Committee

In advance of the

HELP SUBCOMMITTEE HEARING:

Meeting the Moment: Improving Access to Behavioral and Mental Healthcare

Chairman DeSaulnier, Ranking Member Allen, and distinguished members of the Health, Employment, Labor, and Pensions Subcommittee of the House Education and Labor Committee, thank you for the opportunity to submit this testimony for the record on behalf of the over 37,400 psychiatrists of the American Psychiatric Association (APA) for your April 15, 2021 hearing entitled *“Meeting the Moment: Improving Access to Behavioral and Mental Healthcare.”*

The APA is dedicated to providing our physician members with education and training on the most modern evidence-based treatments to diagnose and treat patients with mental illness and substance use disorders (SUD). The APA and our members are focused on ensuring humane care and effective treatment for all persons with mental illness and SUD, and is actively engaged in pursuing policies that affect our patients’ access to quality care. Our sister organization the American Psychiatric Association Foundation (APAF), through its Center on Workplace Mental Health, is a premier source of workplace mental health expertise for employers. APAF also helps to facilitate the availability of culturally competent care through the training of minority fellows entering the field of psychiatry.

In our testimony today, we will highlight data related to access to mental health and SUD care in schools, for employees and for BIPOC communities. We will also use this testimony to offer policy recommendations to alleviate barriers to care with the overarching goal to improve our country’s mental health system, with a particular focus on compliance with mental health parity requirements.

Mental Health in Education and the Workplace

The costs associated with untreated mental illness in the workplace—numbering in the billions of dollars—far outweigh the costs of providing treatment. Yet mental and physical health are both vital to overall health, as is their treatment through integrated, evidence-based care. As the Centers for Disease Control and Prevention has recognized, mental illness, particularly depression, elevates the risk for many other health conditions, such as stroke, type 2 diabetes, and heart disease. The presence of chronic conditions also increases the risk of mental health conditions.

When employees do receive effective treatment for mental illnesses and substance use disorders, the results are seen in lower total medical costs, increased productivity, lower absenteeism and presenteeism, and decreased disability costs. Yet, fewer than half of the 17 million adults with depression in the United States get care for it, with resulting impacts on their personal and work lives. Therefore, it is essential to ensure that the health plans covering employees provide access to the care they need in order to lead healthy, productive lives.

Early identification of mental illness is also essential in preparing children for the workforce and for the healthiest possible life. Half of all lifetime illnesses present in children by the time they are 14 years old, while seventy five percent of lifetime mental illnesses begin by age 24.¹ Further, 1 in 6 youth between the ages of six to seventeen years old experience a mental health disorder each year² and sadly suicide is the second leading cause of death among people between ten and thirty-four years old.³ Early identification for mental health conditions in the primary care setting, through behavioral health integration, and in specialty care, enables early intervention and treatment in the school, family or the medical setting, which helps children become healthy adults.

¹ <https://pubmed.ncbi.nlm.nih.gov/15939837/>

² <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2724377?questAccessKey=f689aa19-31f1-481d-878a-6bf83844536a>

³ <https://www.nimh.nih.gov/health/statistics/suicide.shtml>

In the broader context, we have seen the costs of untreated mental illness for both youth and adults in the concurrent suicide and SUD epidemics that claimed over 300 lives every day prior to the COVID-19 pandemic.⁴ The pandemic has exacerbated this crisis, as evidenced by numerous data: roughly 88,000 people died by overdose in the 12-month period ending in August 2020, a 26.8% increase over the previous 12-month period.⁵

Mental Health Parity Law

In order to reverse these trends, we must first focus on ensuring that people have equitable access to mental health and SUD treatment. Essential to meeting this need is full implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA). The APA applauds the Subcommittee for recognizing this during the 116th Congress and is grateful for the invaluable bipartisan assistance of the Education & Labor Committee and other key congressional committees in amending MHPAEA by including language within the Consolidated Appropriations Act, 2021 (CAA). Section 203 of Division BB of the CAA added important new compliance requirements for group health plans and health insurance issuers, and provided new responsibilities for the federal agencies, most notably the Department of Labor (DOL), to enforce the federal parity law.

Of particular note for the Subcommittee are the new requirements for group health plans subject to the Employee Retirement Income Security Act (ERISA) and the new responsibilities of DOL. Group health plans must now perform comparative analyses that demonstrate their compliance with the nonquantitative treatment limitation (NQTL) requirements of MHPAEA and submit them to DOL upon request. NQTLs include prior authorization, provider network design, reimbursement rate setting, and many other treatment limitations. Importantly, under section 203, plans must perform comparative analyses of all NQTLs, as further reinforced by recent guidance issued by DOL.⁶

DOL must request these analyses from plans whenever there is a complaint or a suspected violation involving an NQTL and in any other instances in which DOL deems necessary. DOL is also required to request analyses from at least 20 plans every year, but given the volume of MHPAEA complaints (92 in 2020) it is likely that DOL will need to request far more analyses than that minimum threshold.⁷ The Employee Benefits Security Administration (EBSA) within DOL will be responsible for this work.

Meeting Federal Compliance Resource Needs

It is important that the EBSA have the resources and capacity necessary to review plan-submitted comparative analyses and are able to take action to correct violations or collect additional information when the initial analyses provided are insufficient. APA has worked with numerous state regulators that collect and review similar comparative analyses. Reviewing these analyses is a time-intensive process that requires expertise and frequent engagement with insurers to ensure that sufficient information is provided. Special templates and tools must be created to collect the necessary information. Regulatory staff must be trained so that they are aligned in how they are interpreting the dense NQTL language

⁴ <https://www.phe.gov/emergency/news/healthactions/phe/Pages/opioids-7April2021.aspx>

⁵ National Center for Health Statistics. National Vital Statistics System. Retrieved from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

⁶ Q8, FAQs ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE CONSOLIDATED APPROPRIATIONS ACT, 2021 PART 45. Retrieved from <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>

⁷ FY 2020 MHPAEA Enforcement Fact Sheet. Retrieved from <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2020.pdf>

from the final rules implementing MHPAEA. Findings of noncompliance must be worded precisely and be firmly grounded within the terminology of the NQTL rules. Providing technical assistance to a plan about what it did that was noncompliant or insufficient can take months. Structuring corrective action plans must be meticulous and provide meaningful and tangible ways for a plan to achieve compliance.

EBSA already faced resource and capacity challenges before new requirements included in the December 2020 CAA were enacted. **Without additional funding, it is unlikely that the EBSA will be able to fulfill these new obligations as Congress intended.** Congress took action last year because there was great concern that plans were not meeting their obligations under MHPAEA, in the face of increasing suicide and overdose deaths. If EBSA is not able to hold plans accountable and implement these new standards, the opportunity to increase access to care and save lives may be lost.

APA recommends that Congress appropriate an additional \$25 million for the EBSA to implement its new responsibilities and ensure that plans are in compliance with the law. This funding would enable EBSA to do the following:

- Hire additional investigators who would focus exclusively on MHPAEA, with special attention on reviewing the comparative analyses and then tailoring investigations of plans based on the information (or lack thereof) within the analyses. Currently EBSA only has 400 investigators whose responsibilities are split among the more than 5 million employee benefit plans. A singular focus on MHPAEA will give investigators the bandwidth to fully immerse themselves in and master the dense and complicated NQTL requirements.⁸
- Hire and retain MHPAEA subject matter expert consultants. While dedicating some investigators solely to parity enforcement will help increase agency expertise, outside subject matter experts in this highly specialized field will be needed to create data collection tools, train numerous agency staff, including the investigators, and help render determinations of compliance or non-compliance on submitted comparative analyses.
- Enhance capacity within EBSA to better tailor investigations and fully investigate plans whose comparative analyses warrant further examination.
- Provide training to benefit advisors who interface with beneficiaries about the new compliance requirements so that they may better inform beneficiaries of their rights.
- Enhance coordination among the 10 DOL regional offices so that there is a uniform approach to understanding and reviewing NQTL analyses.

Given the labor-intensive nature of this specialized compliance work the new responsibilities given to DOL in the CAA will likely require several thousand additional staff hours for adequate and effective implementation.

Meeting State Compliance Resource Needs

APA is also advocating for **additional Congressional action on parity related to the new compliance requirements added by the CAA in the states.** We are supporting the introduction of new legislation that would provide grant funding to state insurance departments for the purposes of implementing the new compliance requirements. While we understand that this legislation may not fall under the

⁸ DOL 2020 Report to Congress. Parity Partnerships: Working Together. Retrieved from <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf>

jurisdiction of this Subcommittee, or full Committee, APA believes this legislation will likely be of interest to you.

Section 203 of the CAA amended MHPAEA so that all state-regulated health insurance issuers must perform the same comparative analyses that group health plans must complete. State insurance commissioners may request these analyses from issuers, and the issuers must supply them to a requesting commissioner. APA has been working with state regulators and state legislatures in recent years to require issuers to submit comparative analyses to insurance commissioners. Since the beginning of 2018, through either legislative or regulatory means, over 20 states have required issuers to submit comparative analyses nearly identical in structure to those in Section 203. Working with these states in particular is how APA developed insight into how time and labor intensive it can be to collect, review, and act upon these analyses.

Through this new legislation, APA is advocating that \$50 million in grant funding be made available for state insurance departments to implement the new comparative analysis specifications. Under the bill, a state would only be eligible to receive grant funding if it requested and reviewed the comparative analyses from issuers. This proposal builds on the precedent set by the Department of Health and Human Services (HHS) in providing such compliance resources to states in 2017 and 2018.⁹ Congress essentially gave every insurance commissioner in America new authority to collect comparative analyses from issuers whenever they deem necessary (most state laws and regulatory processes merely created annual reporting of comparative analyses; not reporting upon request). **Without Congressional action, many states will lack the resources and bandwidth to meaningfully review the analyses.**

This is an issue of great bipartisan interest in the states. Over 30 states are participating in the MHPAEA working group at the National Association of Insurance Commissioners.¹⁰ This formal working group was created in early 2020 after informal meetings revealed the high demand for collaboration and information sharing on effectively implementing mental health parity law.

Though access to mental health care and substance use disorder treatment would be much improved if health insurers all came into compliance with MHPAEA, we cannot begin to improve our country's overall mental health without concurrently addressing health disparities.

Racial Disparities in Mental Health Care

The existence of health disparities is a significant problem facing our country that will not be resolved without direct and sustained intervention targeting the root causes. Systemic racism, intergenerational trauma, persistent poverty, a dearth of cultural competency, and criminalization of mental illness in minority populations, among many other causes, have led to a landscape of stark health disparities that is deeply embedded and resistant to change. As the Subcommittee focuses attention on behavioral health, including compliance with MHPAEA and the impact of mental health on overall health, the APA is eager to work with you to identify bold legislative solutions to meaningfully improve health inequities.

⁹ Center for Consumer Information and Insurance Oversight. Health Insurance Enforcement and Consumer Protection Grants. Retrieved from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Health_Insurance_Enforcement_and_Consumer_Protections-Grants

¹⁰ National Association of Insurance Commissioners MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force. Roster. Retrieved from https://content.naic.org/sites/default/files/inline-files/2021%20B-MHPAEA%20Working%20Group_0.pdf

The pandemic has laid bare the glaring reality of health and healthcare disparities in our country. Data collected during the pandemic has continually indicated that BIPOC individuals experience disparate health outcomes and experience more insurmountable barriers to accessing mental health and SUD care than their white counterparts. These findings continue to play out in our schools, in the health care system and for employers, alike. While health disparities across the spectrum of health outcomes have been further exposed during COVID-19, the extreme disparities and health inequities related to mental health and SUD have been quite clear.¹¹

Denial of necessary mental health and SUD care due to violations of MHPAEA adversely impacts workers and, therefore, their employers. In addition, the long-term adverse impact of structural racism on overall health—physical and mental—is also clear. For example, data show that the COVID-19 virus has disproportionately impacted minority and vulnerable populations, exacerbating the health inequities faced in this country. **A study published on April 6, 2021 in the Lancet found that one-third of individuals diagnosed with COVID-19 developed a neurologic or psychiatric disorder within six months of their diagnosis.** Just as it is in the interest of our society, including employers and workers, to address the COVID-19-specific challenges we have been facing, it is also in our collective interest to intentionally address the racial disparities and health inequities that the pandemic has further exposed.

Cultural competency and disparities in treatment are essential for improving the mental health care of racial/ethnic groups. Compared with the general population, African Americans are less likely to be offered either evidence-based medication therapy or psychotherapy.¹² Physician-patient communication differs for African Americans and whites. One study found that physicians were 23% more verbally dominant and engaged in 33% less patient-centered communication with African American patients than with white patients.¹³ African Americans with mental health conditions, particularly schizophrenia, bipolar disorders, and other psychoses are more likely to be incarcerated than whites.¹⁴ Approximately, 19% of Hispanics are uninsured¹⁵ and those who are insured, are more likely to report poor communication with their health provider. Several studies have found that bilingual patients are evaluated differently when interviewed in English as opposed to Spanish and that Hispanics are more frequently undertreated.¹⁶ Native Americans/Alaska Natives experience post-traumatic stress disorder twice the rate of the general population and suicide among Native youth is higher than any other racial/ethnic group.^{17, 18}

Another barrier to eliminating mental health disparities in underserved communities is the number of mental health practitioners entering the mental health workforce. According to the Health Resources

¹¹ Shim RS. Mental Health Inequities in the Context of COVID-19. *JAMA Netw Open*. 2020;3(9):e2020104. doi:10.1001/jamanetworkopen.2020.20104. Retrieved from

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2770142>

¹² Wang PS, Berglund P, Kessler RC. “Recent care of common mental disorders in the United States: Prevalence and conformance with evidence-based recommendations.” *J Gen Intern Med*. 2000. 15(5), 284-292.

¹³ Johnson R, et al. “Patient race/ethnicity and quality of patient-physician communication during medical visits.” *Am J Public Health*. 2004. 94(12), 2084-90.

¹⁴ U.S. Department of Justice. “Prisoners in 2015.” NCJ 250229 (Bureau of Justice Statistics Bulletin). 2016. <https://www.bjs.gov/content/pub/pdf/p15.pdf>

¹⁵ United States Census. American Community Survey. (2019)

<https://data.census.gov/cedsci/table?q=hispanics%20insurance&tid=ACSDT1Y2019.C27001I&hidePreview=false>.

¹⁶ The League of United Latin American Citizens. Latino Health Disparities. http://lulac.org/programs/health/health_disparities/

¹⁷ Mental Health America. (2020). Native American Communities and Mental Health.

<https://www.mhanational.org/issues/native-american-communitiesand-mental-health>.

¹⁸ Downing, J., & Collier, B. (2020). Native Americans and Mental Health— Seeking Connections Between Historical Trauma, PTSD, Substance Abuse, and Suicide

and Services Administration (HRSA), there are 123 million Americans residing in 5,836 mental health professional shortage areas in the United States. Data indicate that it will require 6,430 mental health providers to enter the workforce to eliminate health professional shortage areas where mental health disparities prevail.¹⁹

In order to alleviate these disparities in access to culturally competent care, the APA strongly urges Congress and this Committee to examine how to recruit and retain more BIPOC individuals into the health care workforce at every level from x-ray technicians to care coordinators to nurses, psychologists and psychiatrists. We cannot begin to combat racial health disparities without making a concerted effort to recruit and retain a BIPOC-representative workforce who can treat patients in communities who look like them. This initiative must start early by encouraging BIPOC students to pursue and excel in science, technology, engineering, and mathematics (STEM) and the health sciences.

In promoting strong STEM and health science-focused elementary and secondary education, we will effectively train and encourage BIPOC individuals to continue their studies through higher education. Institutes of higher learning and technical training-focused organizations need to actively recruit BIPOC candidates and engage in comprehensive career-preparation to help these students go on to work in both the medical practice and medical tech fields. In addition, elementary, secondary and higher learning schools need to offer these students mental health support and services throughout their student careers, as schools are one of the best ways to reach populations plagued by persistent poverty and inequity to health services. By encouraging BIPOC students to pursue STEM and medical field careers and offering these students the MH/SUD supports they need through our education system, we in turn promote both the diversity and the productivity of the next generation of the workforce.

Further, in order to address systemic poverty that has plagued many minority communities, the APA implores Congress, including this Committee, to consider how social determinants of health, including access to high-quality education and social services, food insecurity, access to affordable housing and reliable broadband, lack of transportation, pay inequality, economic security and childhood experiences impact overall health outcomes. Congress should also focus on providing targeted, sustained, investments in community-based support systems that help these communities address social determinants of health. Investments should also be directed towards community organizations that work to help reduce the persistent stigma that serves as a barrier to patients asking for help, especially mental health and SUD treatment, in these communities. APA also encourages Congress to build on the American Rescue Plan Act and increase health insurance coverage, including enrollment of individuals in underserved and BIPOC communities.

The APA looks forward to working together with this Committee and our colleagues across the mental health community to improve our mental health care system and make mental health care accessible for every American. Please consider us a resource for the subcommittee on this and the many other important issues you consider related to behavioral health.

¹⁹ Health Resources and Services Administration. (2020). <https://data.hrsa.gov/topics/health-workforce/shortage-areas>