AMERICAN PSYCHIATRIC ASSOCIATION

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May 25, 2022

Secretary Martin J. Walsh
Office of the Secretary
U.S. Department of Labor
200 Constitution Ave NW
Washington, DC 20210

Dear Secretary Walsh:

On behalf of the American Psychiatric Association (APA), the medical specialty society representing more than 37,400 physicians who specialize in the treatment of mental health and substance use disorders (MH/SUD), we encourage the U.S. Department of Labor (DOL) to re-double its efforts to enforce the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Now more than ever before, our patients need your help in accessing care.

As the COVID 19 pandemic continues to exacerbate MH/SUD, we are seeing rising rates of suicide, record overdose deaths, and increased depression and anxiety across nearly all ages and demographics. As more Americans seek help for mental health challenges, widespread discriminatory practices, such as frequent and more arduous prior authorization practices, extremely limited provider networks, more interference in medical decision making, and improper denials of claims, increase. Although the 2008 passage of MHPAEA prohibited these practices, the promises of parity remain unrealized. Discrimination has grown more egregious over time. In the words of one of our members, "The parity act has been a cruel joke in that insurance companies treat mental health providers and our patients as if it does not exist."

In its 2022 MHPAEA Report to Congress, DOL found numerous parity violations potentially affecting millions of beneficiaries.[1] The Government Accountability Office also found that consumers experience a myriad of challenges – including the existence of "ghost networks" -- in accessing mental health services because their insurance coverage is not in compliance with parity law.[2]

We are all well aware that the insurance plans have no regard for MHPAEA. Indeed, their lack of concern for MH/SUD care access actually increases their profits. Psychiatrists experience firsthand, deliberate efforts by plans to keep psychiatrists

[1] U.S. Department of Labor. (2022). *2022 MHPAEA Report to Congress.* 2022 MHPAEA Report to Congress (dol.gov)
[2]U.S. Governmental Accountability Office. (2022). M*ental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts: Statement of John E. Dicken, Director, Health Care* (Report Number GAO-22-104597). U.S. GAO. p.4. Mental Health Care: Consumers with Coverage Face Access Challenges | U.S. GAO

from joining or remaining in provider networks. Below is input from APA members regarding challenges they are facing in joining and staying with health plan networks.

High administrative and uncompensated burdens. Members recognize their administrative responsibilities in participating in plan networks. However, the administrative tasks have grown exponentially resulting in psychiatrists, particularly those in solo or small practices, spending an inordinate amount of time on uncompensated tasks, leaving far less time for treating patients. Members report routinely having to use a fax machine (when fax machines have not been in use in most systems for years) to secure prior approval for a patient's medication, the plan providing them with incorrect phone numbers for seeking approval and waiting on hold for up to 40 minutes when trying to get approval for patient care.

These practices are designed to discourage physicians from providing necessary treatments and reduce the time psychiatrists are available to treat patients. The result is less time to engage in appropriate treatment activities which reduces patient access and psychiatrist participation in networks, which not coincidentally, decreases plan costs while increasing profit. Our members report:

- "Prior authorizations are the bane of my existence. Denials become more outrageous every year. It is absolutely unbearable. I would retire for this reason only but I will not abandon my patients and I will not stop fighting for them."

- "Each year, I have to fight with insurance to renew longstanding medications that are needed to prevent hospitalization (long-acting injectable antipsychotics) or relapse (buprenorphine) for patients that have repeatedly failed other treatments. Sometimes these are only renewed for 3-6 months at a time, requiring serious administrative burden that is not reimbursed. Some of these, such as Blue Shield, split the appeals process across three or four divisions (medical authorization, mental health authorization, mail-order pharmacy, specialty pharmacy) and place the onus on the clinician and patient to coordinate among these divisions. All of this is harmful to patient care, and an ongoing injury to clinician morale and finances for all of this unreimbursed care."

Low reimbursement rates and plans' refusal to negotiate higher rates. Plans' reimbursement rates for psychiatric care have not been raised for decades. Meanwhile, unreimbursed time spent on administrative tasks has risen exponentially. When psychiatric doctors attempt to negotiate contract provisions, including their rates, plans respond "take it or leave it." Demand for care is skyrocketing. In network provider availability is scarce yet, plans refuse to raise reimbursement rates for psychiatrists. The basic economics of supply and demand suggest the predictable result that is desired by the plans – lack of access to care. "Low reimbursement rates and burdensome credentialing and documentation requirements may discourage behavioral health providers from contracting with health plans"[3] and addressing these barriers could help to improve networks. Our members tell us:

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[3] Bradley, K., Wishon, A., Donnelly, A. and Lechner, A. (2021). *Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards* (Report Number HHSP233201500035I). U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy. p.15. Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards | ASPE (hhs.gov)

- "I am a child psychiatrist who would love to accept commercial insurance and see the children of working people. The administrative burden, risk of inappropriate audit/financial loss, and laughable reimbursement rates make it impossible to take this risk as my family's primary breadwinner. If commercial insurance companies reimbursed us better (including adjusting for cost of living in higher COL areas like the northeast) and did not threaten us with arbitrary audits/UR/pre-auth/etc., I would take insurance to do good for my community."

- **"**The supply and demand dynamics are not reflected in reimbursement. Very tempting to move to self-pay model for that reason, but I feel morally obligated to provide care to long term patients. If reimbursement doesn't improve, we will have to make a choice, since the administrative costs keep climbing up. Reimbursement hasn't even kept up with inflation, let alone reflect supply and demand dynamics."

Threats of audits and claw backs. Our members appreciate that part of their responsibility in belonging to a network is being accountable for accuracy, which is subject to audit. However, the frequency of health plan audits has risen, as have fears around "claw backs" – plans' demands for the return of reimbursement for previously approved and paid claims which can amount to tens of thousands of dollars paid for care provided years ago. These audits are disruptive to patient care, and often require producing large quantities of documents, responding to repeated requests for more documents, and costs of hiring legal counsel. One member told us:

- "Claw-back audits killed me and insurance; I was the last psychiatrist in my county to stop taking insurance."

Psychiatrists want to serve and help patients. They want to join insurance networks and ensure that insured people, regardless of income, will have access to quality care for MH/SUD. Administrative practices of insurance networks – all of which violate MHPAEA – preclude them from doing so. As a result, as the demand for mental healthcare increases, the supply of accessible psychiatric care for insured populations decreases. Insurers are paid by customers and employers to provide care for MH/SUD that they do not provide, and consequently their profits improve. DOL is uniquely situated to end the crisis in MH/SUD treatment.

While APA appreciates the federal government's commitment to ensuring that Americans have access to timely, affordable, and effective MH/SUD care, it must do more. DOL has the authority to investigate and sanction non-compliance with MHPAEA, and it must employ it. Without strong enforcement, we will not be able to serve the increasing demands of those privately insured patients who need care for

MH/SUD. Timing is pivotal and APA stands ready to continue to work with DOL, other federal enforcement agencies, and our members to meet the growing demand for care in this country.

Sincerely,

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CEO and Medical Director
American Psychiatric Association

Cc: Xavier Becerra, Secretary, U.S. Department of Health and Human Services

Janet Yellen, Secretary, U.S. Department of Treasury