March 1, 2019

The Honorable Lamar Alexander, Chair
Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Patty Murray, Ranking Member
Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

Re: Letter in Response to Chairman Alexander's Request to Address Affordability Within the U.S. Health Care System

Dear Chairman Alexander,

Thank you for your request to outside stakeholders requesting comment on what steps the 116th Congress, Trump Administration and/or states should take to address America's rising health care costs. As organizations representing the mental health and substance use disorder community, we too are concerned about the rising costs of health care and the impact these costs have on accessing mental health and substance use disorder services. In turn, we have provided several concepts below to address the growing burden of costs on taxpayers, employers and family budgets. These concepts include:

- Strengthening Parity Enforcement and Compliance at the Federal and State Levels
- Stabilizing the Health Insurance Marketplace
- Behavioral Health Integration

Parity Enforcement and Compliance

Prior to the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, patients paid approximately 35% of benefit costs out-of-pocket for behavioral health care services, compared to only 21% for physical health care services.[1] MHPAEA and federal health care reform have afforded Americans access to needed behavioral health care and treatment, in addition to the knowledge that the real health care costs lies in non-treatment. As the National Business Group on Health has noted, indirect costs associated with mental illness and substance use disorders—excess turnover, lost productivity, absenteeism and disability—commonly meet or exceed the direct treatment costs[2] and can be as high as $193 billion annually.[3]

When we integrate medical and behavioral health care services effectively, an estimated $26-$48 billion can potentially be saved annually.[4] Further, to put these projected savings into context, the total national

[1] Melek, S., Perlman, D., Davenport, S., Matthews, K., and Mager, M. (2017). "Impact of Mental Health Parity and Addiction Equity Act." Milliman. Retrieved from http://www.milliman.com/uploadedFiles/insight/2017/impact-mental-health-parity-act.pdf.
[2] Mental Health America. "Issue Brief: Parity." Retrieved from http://www.mentalhealthamerica.net/issues/issue-brief-parity
[3] National Alliance for Mental Illness. "Mental Health Facts in America." Retrieved from https://www.nami.org/nami/media/nami-media/infographics/generalmhfacts.pdf
[4] National Council for Behavioral Health. The Business Case for Mental Health and Substance Use Disorder Treatment. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2017/10/14_Business-Case_Mental-Health.pdf

expenditures for mental health and substance abuse services provided by all physicians, including psychiatrists, is projected to be approximately $35 billion.[5]

Despite these gains in policy, we know there continue to be implementation challenges related to parity compliance at the federal and state levels. While the responsibility for enforcing mental health parity is shared by the federal government and states, most parity compliance monitoring falls to the state insurance commissioner. However, the federal government has the ability to set the foundation of adherence to the law. Some ways federal and state governments can ensure the 1 in 5 Americans living with a mental illness[6] are treated equitably under the law include:

- Requiring insurance companies to disclose how insurers are making coverage decisions, their denial rates for mental and physical health claims and the rationale for such denials.
- Improve, market and staff federal and state consumer parity portals so that individuals readily access information regarding their parity rights, information from insurers about how they make parity decisions, and receive timely assistance in filing complaints.
- Defining mental health conditions as broadly as "physical" health conditions to include all disorders in the Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD) with no exclusions in state statutes.[7]

Health Insurance Marketplace Stabilization

Actions to address affordability through the repeal of the individual mandate, elimination of cost-sharing reduction (CSR) payments, and expansion of short-term, limited duration plans, and association health plans have ultimately increased costs to Americans in need of comprehensive care. On-exchange silver plan premiums cost 16% higher than would otherwise be the case,[8] and employer-based plans have become increasingly problematic for Americans as deductibles have increased by more than 40% between 2012 and 2018.[9] For short-term plans, 43% don't cover mental health services, 62% don't cover substance abuse treatment, and 71% don't cover outpatient prescription drugs. Further, 45% of adults lacked adequate financial protections from medical bills in 2018, whether because they were uninsured, underinsured or experienced coverage gaps[10]—issues that short-term plans will only exacerbate.

These policy and regulatory decisions fail the 43.8 million adults experiencing a mental illness in a given year and the 10.2 million Americans with a co-occurring mental health and addiction disorder.[11]

Congress can address the rising premium costs and keep comprehensive care through:

- Restricting short-term, limited duration insurance plans to a four-month period to coincide with current policy that allows up to a four-month period before an employer must offer a new employee health insurance coverage.

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[5] Ibid
[6] National Institute for Mental Health. Mental Illness Statistics. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[7] Kennedy Forum. (2018). "32 States Get a Failing Grade on New Report Cards Scoring Statutes for Mental Health and Addiction Treatment 10 Years After Federal Parity Law." Retrieved from https://www.thekennedyforum.org/32-states-get-a-failing-grade-on-new-report-cards-scoring-statutes-for-mental-health-and-addiction-treatment-10-years-after-federal-parity-law/
[8] Kamal, R., Cox, C., Fehr, R., Ramirez, M., Horstman, K., and Levitt, L. (2018). How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums. Kaiser Family Foundation. Retrieved from https://www.kff.org/health-costs/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/
[9] Kaiser Family Foundation (2018). Employer Health Benefits 2018 Annual Survey. Retrieved from: http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018
[10] Collins, Susan, Bhupal, Herman, and Doty, Michelle. (2019). Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps, But More Underinsured. Commonwealth Fund. Retrieved from: http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018
[11] Pollitz, K., Long, M., Semanskee, A., and Rabah, K. (2018). "Understanding Short-Term Limited Duration Health Insurance." Kaiser Family Foundation. Retrieved from https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/

- Reinstating cost-sharing reduction payments.
- Restoring funding for open enrollment outreach and navigators.
- Creating partial subsidies for individuals with incomes above 400 percent of the federal poverty level to mitigate the subsidy cliff that occurs presently.

Behavioral Health Integration

Integration of behavioral health care continues to be a challenge and leads to lower quality of care, lower patient satisfaction, and increase costs to the U.S. health care system. There are several ways to address integration of care including:

- *Setting Integration Goals and Providing Resources to Providers*

Despite recent efforts by CMS to support behavioral health integration, most Americans still face delays in accessing necessary mental health and substance use care. To reach a tipping point in behavioral health integration, Congress should encourage CMS to engage public-private partnerships of payers, providers, and patients to set clear goals for effective behavioral health integration and pursue policies that support diverse providers to screen regularly for needs and ensure that every American has access to integrated behavioral health care, regardless of whether they live in a rural or urban area or what kind of insurance they have.

One of the greatest cost burdens are for chronic conditions, which affects 60% of adults and account for over 70% of costs.[12] Individuals with non-communicable diseases are at higher risk for a mental health condition, which underscores the importance of integrating mental health providers as a way to improve care and manage cots.

While providers will need different kinds of support to integrate behavioral health into their practices, part of it will be making available a wider array of tools for providers, including examining flexibility for telehealth, certified peer support specialists, interdisciplinary consultation and collaboration, digital health interventions, or other approaches that could better serve Americans that face barriers to access today.

- *Make Value-Based Payment work for Behavioral Health*

Historically, the focus of alternative payment models (APMs) has been on the medical/surgical side of care, despite the fact that health care costs for patients with comorbid behavioral health conditions are 2.5 to 3.5 times that of their physical peers.[13] Among existing models, for example, Accountable Care Organizations (ACO) have not meaningfully included behavioral health providers, either in forming ACOs or in having patient responsibility in ACO networks assigned to them. Two studies published in the July 2016 *Health Affairs* suggested that Medicare ACOs had had only limited success in improving the management of mental health. In the first study, ACOs were found to have resulted in no changes in mental health admissions, increased outpatient follow-up after mental health admissions, increased diagnoses of depression, or improved mental health status.[14] The authors suggested that ACOs might not be well-positioned to manage behavioral health care because of limited organizational integration of

[12] Buttorff, Christine; Ruder, Teague and Bauman, Melissa. (2017). Multiple Chronic Conditions in the United States. RAND Corporation. Retrieved from https://www.rand.org/pubs/tools/TL221.html

[13] Mauri, A., Harbin, H., Unutzer, J., Carlo, A., Ferguson, R., and Schoenbaum, M. (2017). "Payment Reform and Opportunities for Behavioral Health: Alternative Payment Model Examples. Scattergood. Retrieved from https://chp-wp-uploads.s3.amazonaws.com/www.thekennedyforum.org/uploads/2017/09/Payment-Reform-and-Opportunities-for-Behavioral-Health-Alternative-Payment-Model-Examples-Final.pdf

[14] Busch A.B., Huskamp H.A., and McWilliams J. M. (2016). Early Efforts by Medicare Accountable Care Organizations Have Limited Effect on Mental Illness Care and Management, *Health Affairs*, pp.1247-56, Retrieved from: https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1669

behavioral health and primary care providers. The second July 2016 *Health Affairs* article[15] offered a more optimistic outlook than the first, finding that 90 organizations participating in Medicare ACOs from 2012 to 2015 achieved mixed degrees of engagement in improving behavioral health care for their enrollees.

ACOs in the private sector have generally followed the approach taken by ACOs under the Medicaid and Medicare programs, with only physicians being allowed to assume assignment responsibility. Allowing ACO-participating behavioral health care providers—psychiatrists, psychologists, psychiatric-mental health nurses, and social workers to assume assignment responsibility (and responsibility for the ACO's savings and losses) would incentivize existing ACOs to include those providers and allow behavioral health providers to form new ACOs focused on integrating general medical care with behavioral health care. CMS should also support existing ACOs in including behavioral health providers and improving their behavioral health outcomes as a priority area of focus.

For behavioral health-specific APMs, one example to decrease costs is by utilizing a bundled rate or other APM to support the delivery of the full array of services and supports delivered in evidence-based interventions such as Coordinated Specialty Care for First-Episode Psychosis programs (CSC). Research has shown that CSC programs improve outcomes and cost $1,368 *less* per patient per 6 months compared to usual care if the time to treatment is less than 74 weeks.[16]

In order to make meaningful, effective and long-lasting change within the U.S. health care system, we need to make long-term investments. If we continue to look for cost saving measures in the short-term, we will continue to fall short for American families, providers and employers. We thank you again for the opportunity to provide solutions that can make health care more affordable. We look forward to continuing to work with you and colleagues on this important issue this Congress.

Sincerely,

American Art Therapy Association
American Association of Child and Adolescent Psychiatry
American Association on Health and Disability
American Association for Psychoanalysis in Clinical Social Work
American Foundation for Suicide Prevention
American Mental Health Counselors Association
American Nurses Association
American Psychiatric Association
American Psychological Association
American Psychiatric Nurses Association
Association for Ambulatory Behavioral Healthcare
Campaign for Trauma-Informed Policy and Practice
Clinical Social Work Association
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy and Action
International OCD Foundation
The Jewish Federations of North America
Mental Health America

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[15] Fullerton C.A., Henke R.M., Crable E., Hohlbauch A., and Cummings, N. (2016). The Impact of Medicare ACOs on Improving Integration and Coordination of Physical and Behavioral Health Care, *Health Affairs*, pp. 1257-65, Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0019

[16] Rosenheck, R., Leslie, D., Sint, K., Haiqun, L., Robinson, D., Schooler, N., Mueser, K., . . . Kane, J. (2016). Cost-Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program. *Schizophrenia Bulletin*, 42: 4, 896-906. doi:10.1093/schbul/sbv224

National Alliance on Mental Illness
National Association for Behavioral Healthcare
National Association of State Mental Health Program Directors
National Council for Behavioral Health
National Federation of Families for Children's Mental Health
National Register of Health Service Psychologists
Psychotherapy Action Network
Residential Eating Disorders Consortium
Sandy Hook Promise
The Confederation of Independent Psychoanalytic Societies
The Kennedy Forum
The National Alliance to Advance Adolescent Health
Treatment Communities of America