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September 11, 2020

The Honorable Frank Pallone, Jr.
Chair, Energy and Commerce Committee
US House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone,

Thank you for the invitation to testify as a witness before the Energy and Commerce Subcommittee on Health at the June 30, 2020 hearing entitled "*High Anxiety and Stress: Legislation to Improve Mental Health During Crisis."* Per the requirements of my participation in the hearing, I am submitting the following in response to your questions for the record. Please find your questions and my answers to these questions below.

**The Honorable Frank Pallone, Jr. (D-NJ):**

Mental Health Parity

The Mental Health Parity and Addition Equity Act of 2008, also known as the Federal Parity Law, intended to ensure equal coverage treatment of mental health and substance use disorder benefits. Prior to enactment of the Federal Parity Law, insurance companies unfairly limited consumers' access to mental health and substance use disorder benefits. The law helped improve vital access to mental health and addiction services for individuals. However, there are significant gaps that still exist between mental health services and general medical services. Last year, we reached a bipartisan, bicameral agreement on legislation to lower health care costs, which also included an important provision that would strengthen parity in mental health and substance use disorder benefits. The Committee has also passed H.R. 7539, the Strengthening Behavioral Health Parity Act. The bipartisan legislation would help improve and strengthen enforcement of existing mental health parity laws.

***Chairman Pallone Question*** *-- Dr. Geller, could you discuss why it is critical that insurance plans conduct comparative analyses of the nonquantitative treatment limitations used for behavioral health as compared to medical and surgical benefits?*

**Dr. Geller Answer** – It is critical that insurance plans conduct comparative analyses because it is impossible for them to know if they comply with the 2008 Mental Health Parity and Addiction Equity law without doing this. The Federal Parity Law is fundamentally a comparative law. Given the complexities of the law and health insurance design, detailed and thorough analyses are necessary to assess the degree to which a plan is in compliance. The only way a plan can meet the requirements of

the law regarding nonquantitative treatment limitations for behavioral health benefits is if everything concerning the design and application of those benefits is comparable to how this is done for medical and surgical benefits. This requires the plan to examine how it designed the benefits, what it relied upon when it designed them, and what happened when the benefit designs were applied, and then use comparative tests to determine if the psychiatric care benefits' design and operation were discriminatory, as defined by the law. Given the difference in treatments for psychiatric care versus physical health, this analysis is essential to ensure legal compliance. If a plan has not performed comparative analyses, there is no other way to determine if they are complying with the law. Unfortunately, numerous investigations by state insurance departments and the Department of Labor have revealed that most plans simply have not conducted these comparative analyses. In fact, plans sometimes say they do not have to perform these analyses. Therefore, the parity provisions in the bipartisan, bicameral agreement contained in H.R. 7539 are needed. With the passage of H.R. 7539, what is already implied by the Federal Parity Law will be explicitly required in statute. Passage will require plans to conduct comparative analyses of nonquantitative treatment limitation design and application for behavioral health benefits versus medical and surgical benefits.

***Chairman Pallone Question*** -- It is critical that we increase transparency regarding how health insurance plans are complying with the Federal Parity Law and the treatment limitations used for behavioral health. Currently insurance companies are not required to notify consumers if they are found to be in violation of mental health parity laws. Dr. Geller, could you briefly discuss how consumers could benefit from such a notification?

**Dr. Geller Answer** – Requiring insurance plans to notify consumers when they are found to be in violation of parity law can be beneficial for consumers and their families. Few patients are aware that the law requires plans to ensure that behavioral health insurance coverage be no more restrictive than medical and surgical coverage. Today when consumers encounter violations of the law, their response is often one of resignation-- they believe they will not receive the behavioral health coverage they need because that is the way it has always been. Families often incur enormous debts to pay for services that require them to take out second mortgages, deplete retirement accounts, and drain college funds or even go bankrupt to keep their loved ones alive and in treatment. If consumers are notified that their plan has been found in violation of the Federal Parity Law they will have a chance to appeal or seek legal remedy if they paid out-of-pocket for care, or they will be empowered to seek treatment again if the illegal practice had caused them to forgo treatment altogether. Notifying consumers when their plans have been found in violation of the parity law has the potential to reduce the financial hardship on consumers and families when seeking behavioral health care and will hopefully lead to more people getting needed treatment. This is particularly true when combined with stronger enforcement by the regulators who understand the technical nuances of the law and can hold insurers accountable in ways consumers typically cannot.

Supporting Suicide Prevention Through a Lifeline

We know that rates of suicide were rising to alarming levels prior to the coronavirus pandemic. As we heard at our hearing, the distress caused by this public health emergency is only exacerbating what we knew. A report from Well Being Trust estimates an additional 75,000 will die by suicide/death by despair as a result of this pandemic and about 4,000 of those deaths will be youth. Sandy Hook Promise's 24/7 crisis center, which receives reports from schools and students across the country, has seen over a 10 percent increase in suicide tips.

***Chairman Pallone Question*** *-- H.R. 4585, the Campaign to Prevent Suicide Act, and H.R. 4564, the Suicide Prevention Lifeline Improvement of 2019, are intended to support the 9-8-8 number when it becomes active. Why is the increased support and educational campaigns included in these bills crucial to the effectiveness of the new 9-8-8 number?*

**Dr. Geller Answer** -- An educational campaign is critical to reaching individuals at risk and targeting rural and underserved populations and others who otherwise might not be aware of the 9-8-8 dialing code. An assessment plan, which would require metrics to measure operations for the hotline, including the adequacy of infrastructure for assisting those who want to help someone else in crisis, will facilitate future planning and continuous improvements to hotline operations. While swift implementation is vital, there will be lessons to learn as the number is implemented and efforts grow to enhance infrastructure to facilitate crisis response at the state and community level. A long-term financial commitment and long-term education campaign will be critical to operating a well-functioning, life-saving 9-8-8 hotline.

Mental Healthcare in the ER Setting

Among the pieces of legislation we considered at our hearing were H.R. 2519, the *Improving Mental Health Access from the Emergency Department Act of 2019*, introduced by Rep. Ruiz, and H.R. 4861, the *Effective Suicide Screening and Assessment in the Emergency Department Act of 2019*, introduced by Reps. Engel and Bilirakis. These bills would support mental health services in emergency rooms and better equip emergency rooms (ER) to identify and treat patients at risk for suicide.

***Chairman Pallone Question*** -- Dr. Geller, in your testimony you discussed the importance of equipping emergency rooms to handle suicidal patients or refer them to timely appropriate care, and of the implementation of suicide screening and identification protocols to reduce deaths in ER settings as well as post-discharge. You emphasized the importance of appropriately addressing cases of mental health crises in the ER setting and preventing patients from languishing in the ER while waiting for treatment. Why is improving conditions for mental health patients who visit the ER setting so critical?

**Dr. Geller Answer** – As I said in my testimony, the provision of psychiatric care in our country is incredibly fragmented and underfunded. Unfortunately, our emergency rooms often have long wait times and psychiatric patients end up languishing in waiting rooms because of the lack of inpatient psychiatric beds, lack of available clinicians, or both. Insufficient funding for lower levels of care from community clinics, intensive outpatient programs, community crisis stabilization units, and respite services, also fuels crises and leads patients to seek care in emergency settings. To ensure that patients receive the right care at the right time, it is imperative that we improve overall access to psychiatric services so that patients are able to access care before they experience a crisis. However, for those patients who experience psychiatric crises or overdoses and present in the emergency room for care, approaches can be taken to improve treatment and patient outcomes, including reducing agitation and using de-escalation tactics to calm a patient, evaluating for medical comorbidities, providing active psychiatric treatment, and using observational units. The APA released a Resource Document on these strategies and potential solutions in 2019 that can be found here. Faster access to psychiatric care can be the difference between quickly stabilizing a patient and getting them back on their feet and preventing an overdose or a suicide attempt.

***Chairman Pallone Question*** -- What are the typical outcomes for patients unable to access appropriate, timely care in the ER setting?

**Dr. Geller Answer** – Patients unable to access appropriate, timely psychiatric care in the ER often languish in the ER and their condition deteriorates. Being forced to wait can result in a worsening of symptoms and compound a psychiatric crisis. These patients also can become frustrated with the wait and sometimes walk out of the ER, which leaves them in an even more unsafe environment without access to help. Further, the ER may prematurely discharge patients due to lack of any source for continued care or state statutory requirements.

***Chairman Pallone Question*** -- What other changes in your view need to be made to improve our healthcare system for patients experiencing a mental health emergency?

**Dr. Geller Answer** – The lack of inpatient psychiatric beds exacerbates the challenges the committee is attempting to address with virtually every bill that was discussed in the June hearing, as does discrimination (stigma) against those with mental illnesses. Now, with COVID-19 compounding the ongoing opioid and suicide epidemics, we are in the middle of an even larger psychiatric crisis that requires more resources at every level of psychiatric care, especially addressing individuals needs early before they end up with a psychiatric emergency. Nearly all the bills heard by the Committee during the June 2020 hearing are a promising start. However, Congress could help address the impending COVID-19 psychiatric crisis by increasing access to psychiatric care services and substance use treatment through evidence-based integrated care programs, increasing funding for inpatient beds, ensuring communities are incentivized to provide services along a continuum of care, bolstering the mental health workforce by increasing incentives for medical students to pursue careers in psychiatry, increasing GME funding to psychiatry residency programs, and increasing loan repayment and forgiveness programs. Congress could also further incentivize the use of telehealth to extend our workforce and could boost access to broadband and secure technology for underserved communities.

***Rep. Barragán Question*** -- I know parity laws exist to prohibit health insurance plans from imposing less favorable benefit limitations on mental health and substance use disorder treatment. However, I am concerned that limitations may still exist. For instance, I have heard of individuals being limited in the number of visits they can have with a mental health professional over the course of a year. How common is the situation I described, and if people who need to speak regularly with a mental health professional have limited access, what are the potential negative consequences?

**Dr. Geller Answer** – You have every reason to be concerned because the example you have provided is still happening far too often across the country. Eliminating these numerical limits on treatment was supposed to be the easy part of the Federal Parity Law for plans to follow. However, investigations by state regulators and the Department of Labor still find similar violations quite often, in addition to the many violations they find regarding the more complicated parts of the law. Even when plans have eliminated these numerical limitations, they have replaced them with medical management practices that ultimately have the same effect of limiting access. For example, many plans do not have hard limits anymore, but instead require prior authorization for any visits after a certain numerical threshold has been reached. Then, when the prior authorization occurs, the plan makes it virtually impossible for the additional visits to be approved. When people who need regular outpatient behavioral health visits to sustain and strengthen recovery cannot get that care, they instead either pay out-of-pocket at great expense or simply do not receive the treatment they need. This leads to financial strain, worsening symptoms, or both. Further, the patients may resort to using drugs and alcohol as a form of "self-

medication." Discriminatory limits often cause someone to receive no care or limited care, which then leads to acute crisis, hospitalization, and even death.

***Rep. Blunt Rochester Question*** -- I'm a cosponsor of H.R. 7080, the *Stopping Mental Health Pandemic Act*, which will help address behavioral health needs caused by COVID-19, including supporting outreach to underserved and minority communities. Can you discuss mental health stigma among communities of color?

**Dr. Geller Answer** – Unfortunately, stigma exists surrounding the need to access psychiatric care, and particularly within communities of color. We know that individuals who receive treatment from members of their community who look like them, are more receptive to care. Many individuals often feel comfortable approaching their primary care physician with mental health concerns and data has shown when psychiatric services are integrated into primary care, individuals are more likely to continue treatment. Ensuring there is an adequate workforce with providers from diverse backgrounds, cultural competency training among providers, access to culturally competent approaches to treatment, including but not limited to trauma-sensitive approaches to care can begin to address stigma in communities of color. In this pandemic alone, preliminary data has shown that the COVID-19 virus disproportionately impacts minority and vulnerable populations. We cannot begin to remedy systemic issues within health care access and delivery if we do not first have quantifiable data from which to inform our policy proposals. Access to this type of information would empower healthcare providers to allocate the resources to get culturally appropriate information and care to affected individuals in underserved communities.

Perceived racism and discrimination—either overt or covert (microaggression) or in the forms of implicit or explicit bias—have been associated with depression, anxiety, increased substance use, feelings of hopelessness, and suicide ideation in black adults and youth (Gibbons, 2004; Nyborg, 2003; O'Keefe 2014). We encourage the Committee to examine policies that require the Department of Health and Human Services (HHS) to collect, analyze, and make available to the public, explicit, comprehensive, standardized data on race and ethnicity related to testing availability and related morbidity results, hospitalization, and mortality associated with COVID-19. Such data can then be used to inform the development of improved, evidence-based strategies to address the unique psychiatric needs of communities of color.

We also would like to express our gratitude for your continued support of the *Minority Fellowship Program,* which supports the development of a more culturally diverse medical workforce and provides vital support for fellows to continue to work in the communities in which they complete their fellowships.

***Rep. Blunt Rochester Question*** -- In addition to supporting targeted outreach and education, what policies do you recommend that Congress focus on to close racial health disparity gaps in mental health?

**Dr. Geller Answer** – As I said in my testimony, we know that the COVID-19 pandemic has disproportionately impacted communities of color and is expected to have grave and potentially long-term mental health implications owing to the traumatic stress associated with pandemic conditions. For communities of color, additional environmental strains such as poverty, unsafe neighborhoods, and chronic racial discrimination, among other social determinants of health, can significantly increase distress and the overall mental and emotional well-being of youth. Furthermore, Black adults are 20 percent more likely to report serious psychological distress than their white peers as reported by the

U.S. Department of Health and Human Services Office of Minority Health. But to close the racial health disparity gap, we need more research that shows statistics like this.

While some cultural factors do contribute to disparities, under-utilization is also a symptom of the problems that cause the gaps in access to psychiatric services in communities of color. We need more psychiatric providers of color in minority communities so that patients see their providers as peers and are more comfortable discussing their concerns with these providers who look like them. Congress can take one useful step by increasing funding for the Minority Fellowship Program. In addition, Congress should consider legislation that assists health care workers in implementing crisis intervention services and trainings in communities. Congressional support for communities is essential in helping them adopt and implement psychiatric crisis care services and interventions as a healthier and more effective replacement in lieu of institutionalization and incarceration. By connecting individuals in need to trained psychiatric professionals, instead of sending them to the emergency room or to the justice system, we can reduce stigma surrounding psychiatric conditions and services, provide culturally competent care, and reduce racial disparity gaps in access to psychiatric care.

Finally, we need research. There are not enough studies that look specifically at the factors that affect the collective and individual mental health of communities of color. We need data accounting for all aspects that can contribute to disparities, ranging from lack of trained teachers to lack of financing for community services, transportation, and other social determinants of health. We also need to closely examine barriers to people of color entering the medical education pipeline and encourage more persons of color to join the psychiatric clinician workforce.

***Rep. Blunt Rochester Question*** -- How are Medicare beneficiaries at risk for isolation mental health issues as a result of the COVID-19 pandemic?

**Dr. Geller Answer** – Seniors who do not have significant health issues are often able to remain in their own homes. Remaining in the home is typically beneficial for seniors. However, remaining in the home often means that seniors are living alone. Living alone can be physically and socially isolating for anyone. However, given that seniors are particularly vulnerable to COVID-19 infections, many loved ones, friends, and neighbors have stopped regularly visiting seniors as they continue to take physical distancing compliance seriously during the pandemic. This is true whether seniors live in their own homes, in senior living communities, or nursing facilities. This situation has cut off vital lines of social interaction for many seniors and can have the unfortunate side effect of worsening depression, anxiety and other mental and physical health conditions. Further, given the limited interaction seniors can have with their families during COVID-19, tasks that seniors have typically received help from family, friends, neighbors, or home health agencies to complete, like grocery shopping, laundry, help with medications, cooking or bathing, are made more difficult.. The lack of human interaction combined with lack of assistance in doing everyday tasks can worsen already existing psychiatric conditions and create new ones. As the pandemic wears on, it is vital that seniors interact with family, friends, and other loved ones virtually, or if necessary, safely in person, only if every precaution is taken to protect them from COVID-19. In addition, access to telehealth via video or telephone can help to reduce isolation and ensure that seniors receive the care they need.

***Rep. Blunt Rochester Question*** -- H.R. 945, *the Mental Health Access Improvement Act of 2019*, would provide for coverage of marriage and family therapist services and mental health counselor services under Medicare. What role can mental health counselors and marriage and family therapists play in addressing mental health issues as a result of COVID-19?

**Dr. Geller Answer** – I want to start by noting that the APA has not taken an official position on H.R. 945. However, marriage and family therapists play important roles in both relationship and family counseling and are a vital part of a patient's care team. Marriage and family therapists can help families and people in relationships work on their anxiety management skills to effectively keep their worries about getting sick, losing their jobs, or other pandemic-related worries in check. These mental health care workers can also help families deal with grief if family or friends become sick or pass away because of the COVID-19 virus. Marriage and family therapists can also be a lifeline for patients who need referrals to a psychiatrist as their psychiatric condition, including anxiety and depression, may have gotten worse during the pandemic. Psychiatrists work together with all types of mental health care workers across the continuum to ensure that each patient is able to access the appropriate level of care he or she needs.

***Rep. Bilirakis Question*** -- Dr. Geller – Congresswoman Porter, Congressman Norcross, and I introduced H.R. 3165, the *Mental Health Parity Compliance Act*, which would require health plans to submit comparative analyses upon request from federal oversight agencies to ensure compliance with existing mental health parity laws. Can you discuss some of the gaps in federal law that have contributed to a lack of true parity when it comes to psychiatric coverage and how the increased transparency provided under the *Mental Health Parity Compliance Act* would help?

**Dr. Geller Answer** – First, we thank you Congressman for your leadership on H.R. 3165. Your bipartisan work on parity is exactly what we need to ensure that the promise Congress made to Americans with the Federal Parity Law in 2008 is kept. The most significant gap that continues to prevent genuine parity is the lack of an explicit requirement for insurance plans to perform comparative analyses of their behavioral health benefits versus their medical and surgical benefits. Although it strains credulity for plans to say that they don't already have to perform these analyses given the fundamental comparative nature of the Federal Parity Law, that is what they frequently say when asked about their comparative analysis practices. Thankfully, that is exactly what the *Mental Health Parity Compliance Act* does -- it requires plans to make these analyses available to the Department of Labor and state regulators upon request. The bill will facilitate the transparency necessary to ensure that individuals who need mental and behavioral health treatment get the coverage they deserve.

***Rep. Bilirakis Question*** -- As states are primarily responsible for regulating insurance plans, what have states done to address gaps in mental health parity, and why is legislation needed federally?

**Dr. Geller Answer** – Since 2018, states have passed bipartisan legislation in red and blue states that close gaps in parity. State bills have focused on insurer transparency regarding their design and application of behavioral health benefits compared to how they determine benefit parameters for medical and surgical benefits. Twelve states have passed this type of legislation and more are expected do so later this year and in coming sessions. But, as you know, states have no ability to regulate employer-sponsored health plans that self-insure (ERISA plans). States can only regulate policies that are directly purchased by an employer from an insurer. In recent years employers have been self-insuring more often, rather than buying policies directly from insurers. This means that millions upon millions of Americans are covered by health plans that are beyond the reach of state oversight. Therefore, an act of Congress is necessary to ensure true parity for self-insured health plans. The *Mental Health Parity Compliance Act* accomplishes what is needed in terms of closing gaps in coverage and increasing transparency. The legislation takes the same approach to achieving transparency as the state measures that have been signed into law by Republican and Democratic governors alike. Again, we applaud you

for your bipartisan leadership on this issue that is critical to ensuring patients have access to the mental and behavioral health services they need.

Thank you again for providing me with the opportunity to testify and respond to follow-up questions for the record. Kindly let me or the staff at the APA know if you have any follow-up questions or need additional information.

Sincerely,

**Jeffrey L. Geller, MD, MPH**
**President**