WELL BEING TRUST

Levers for Action:
Federal and State Opportunities in 2021 and Beyond

December 10, 2020

HEALING THE NATION

Advancing Mental Health
and Addiction Policy

OUR SPEAKERS

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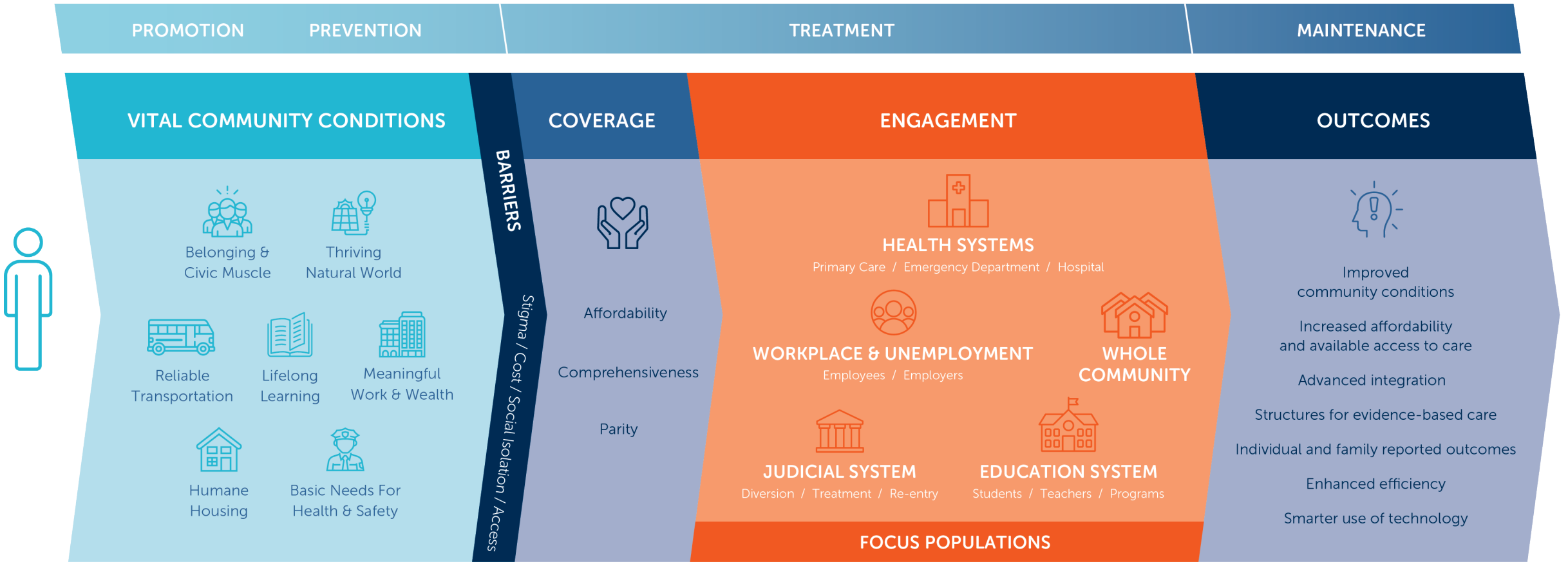
Framework for excellence in mental health and well-being

The framework for excellence in mental health is a guide for changemakers at every level of society who seek to improve mental health outcomes and promote well-being for millions of Americans.



David Lloyd
Senior Policy Advisor,
The Kennedy Forum

2019 Milliman Report

Large Out-of-Network Disparities Are Increasing

Delaware

(one of the highest drug overdose rates)

Inpatient MH/SUD treatment: Approximately **29 times** more likely to be out-of-network than inpatient medical care.

Maine

(suicide rate far above the national average)

Inpatient MH/SUD treatment: Approximately **38 times** more likely to be out-of-network than inpatient medical care.

- Primary care providers paid **24%** more than MH/SUD providers for office visits

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Generally Accepted Standards of Care

- In *Wit v. United Behavioral Health*, a federal court ruled that UBH's coverage practices and medical necessity criteria were inconsistent with Generally Accepted Standards of Care.
- Ordered UBH to reprocess 67,000 claims for 50,000 members nationwide (half of whom were children/adolescents). Use level of care criteria from non-profit clinical specialty associations.

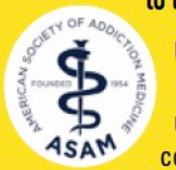
Insurers wouldn't dare deny someone coverage for medical treatment following a heart attack.

UBH's flawed criteria was designed to approve coverage with a primary focus on "acute" episodes, such as withdrawal or suicidal behavior. This is not sufficient, given that mental health and substance use disorders, like other conditions such as diabetes and heart disease, most often require long-term care.

Doctors should be calling the shots for treatment, not insurers.

Additionally, UBH's criteria required reducing the level of care, *e.g.*, from residential treatment to outpatient therapy, even if the treating providers – consistent with generally accepted clinical standards – believed maintaining a higher level of care was necessary.

UBH broke several state laws pertaining to the use of review criteria.



UBH failed to use evidence-based criteria for substance use disorders that are consistent with criteria developed by nonprofit, clinical specialty organizations such as the American Society of Addiction Medicine (ASAM). This is required in states such as Connecticut, Illinois, and Rhode Island.

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Generally Accepted Standards of Care

The Wit Court Identified 8 Standards for Behavioral Health Care:

1. Treat underlying condition, not only current symptoms.
2. Treat co-occurring conditions.
3. Treat at the least intensive level of care that is safe and just as effective as higher level of care (cannot sacrifice effectiveness because a treatment is equally safe).
4. Err on the side of caution by using a higher level of care when there is ambiguity.
5. Include treatment services to maintain function.
6. Determine duration based on the individual's needs, without arbitrary limits.
7. Address unique needs of children/adolescents into account.
8. Use a multidimensional assessment to determine level of care (e.g., LOCUS, ASAM criteria).

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Senate Bill 855 – California

Landmark Legislation Enacted in California

WHERE WE ARE

A record **71,000** Americans died of drug overdoses in 2019; California deaths surged nearly **16%**.
(Source: CDC)

Nearly **1 in 6** adults in California live with mental illness, and 1 in 24 have a serious mental illness that makes it difficult to carry out major life activities.
(Source: CA Health Care Foundation)

90% of Californians with a substance use disorder do not receive treatment.
(Source: CA Health Care Foundation)

California alone could suffer over **22,500** additional deaths of despair from suicides, overdoses, alcohol poisoning, or liver disease caused by alcohol – due to COVID-19.
(Source: Well Being Trust)

ROADBLOCKS TO MENTAL HEALTH & ADDICTION CARE

The existing California Parity Act excludes substance use disorders and most mental health disorders, thus opening the door for insurers to deny treatment coverage by not following nationally recognized standards of care.

Families are often forced to forgo treatment due to huge out-of-pocket expenses. And the costs ultimately shift to taxpayers in the form of homelessness, overdoses, unemployment, and more.

Last year in the **Wit v. United Behavioral Health** ruling, a federal judge in California blasted the country's largest health insurer, United, for denying mental health claims **"based as much or more on its own bottom line as on the interests of the plan members."** These discriminatory actions must be stopped.

WHERE WE NEED TO BE

SB 855, (Wiener) will update the CA Mental Health Parity Act to ensure that people can get help for mental health and substance use disorders—covered by insurance—before they're in crisis.

The bill would require the use of evidence-based, nationally recognized standards of mental health and addiction care in determining treatment coverage— at no cost to the General Fund.

In addition to helping Californians access care, **SB 855** will reduce the enormous costs to Medi-Cal and other public programs associated with untreated mental health and substance use disorders.

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New State Model Bill

Released this morning by Kennedy Forum, American Psychiatric Association, Well Being Trust, Inseparable, and 30+ other national orgs

- Requires **coverage of medically necessary MH/SUD care for all DSM diagnoses**
- **Defines "medical necessity"** based on AMA/APA supported definition
- Requires plans to follow **Generally Accepted Standards of Care**
- Requires plans to use most recent editions of **criteria/guidelines from non-profit clinical specialty associations** (e.g. ASAM)
- Requires **out-of-network coverage** if services are not available in-network within timely / geographic access standards (at in-network cost sharing)
- May not limit services because they should/could be covered by a **public program**
- Requires **training / testing** on how criteria being used
- Prohibits the use of **discretionary clauses**

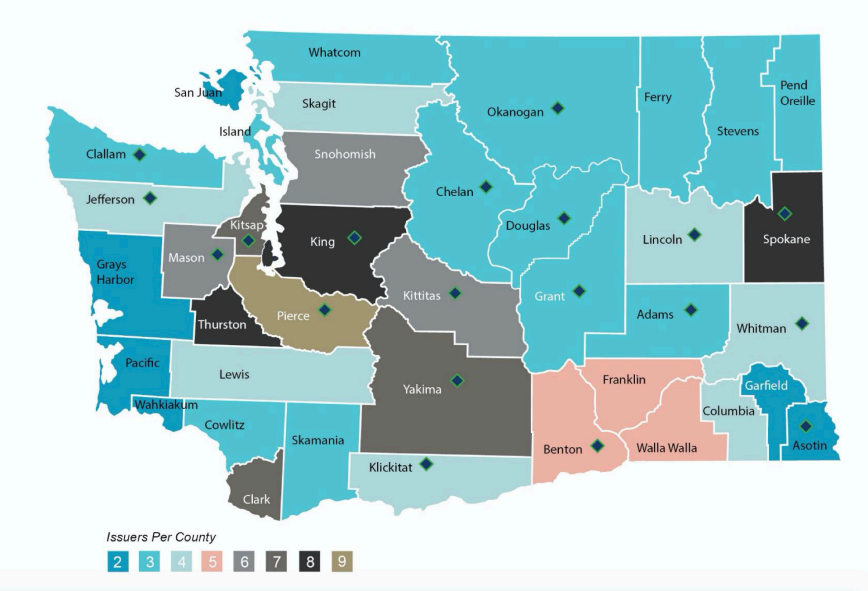
THE KENNEDY FORUM

Jane Beyer
Senior Health Policy Advisor,
Washington Office of the
Insurance Commissioner

Washington State: Progress and Regulation

OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

Washington Health Benefit Exchange



- ~80% of people who purchase individual coverage do so via exchange
- 13 carriers offering on the Exchange
  - Community Health Network of Washington, Regence, and UnitedHealthcare new for 2021
- All counties have carrier choice: 2+ options in all counties
  - 8 counties with one carrier in 2020
- A total of 115 QHPs for 2021
  - In King, Pierce, and Thurston Counties, consumers will have 69-73 plan options
  - In 2020, 43 QHPs statewide and most plans offered in a county is 35
- Average 2021 rate decrease from 2020 rates is -2.4%*

COVID-19 & Telehealth

Executive Action

- Promoted payment parity and broadened methods to provide telemedicine, including allowing telephone in addition to audio/visual modalities. Still in effect.

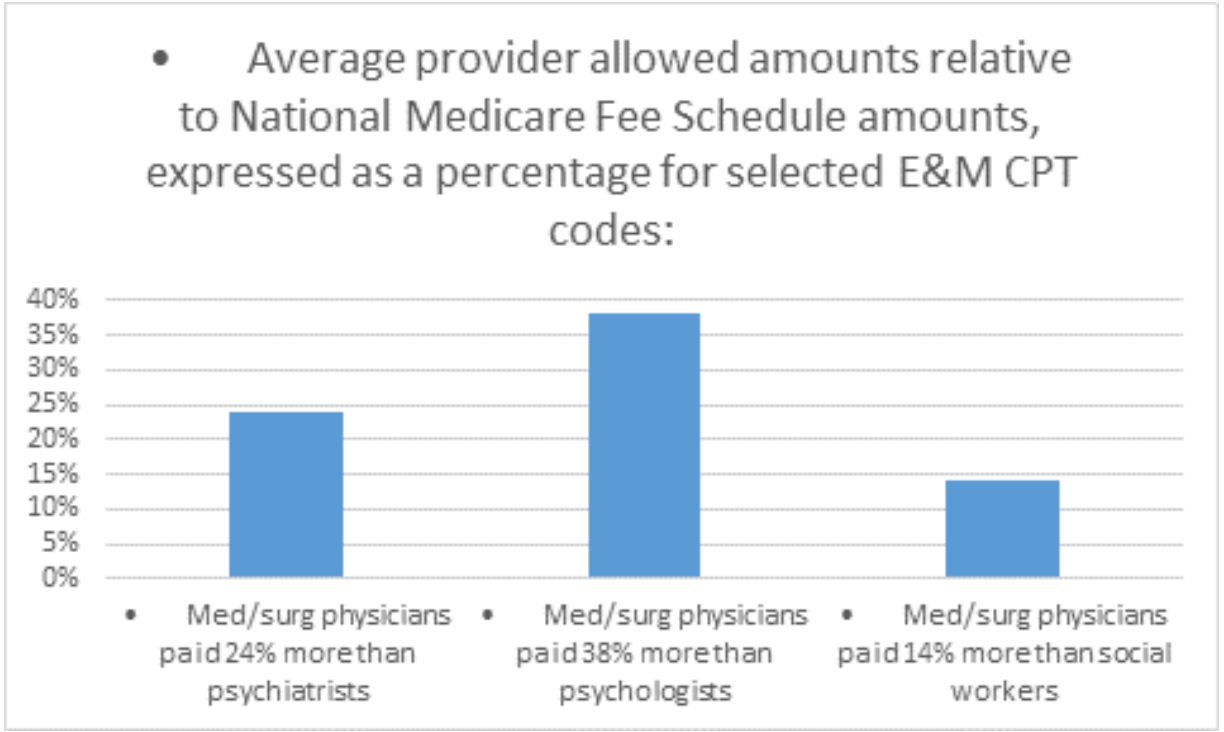
2020 Legislation Implementation

- SHB 2338 (Chap. 228, Laws of 2020): Strikes exclusions related to substance use disorder (SUD) and gender-related mental health conditions from state behavioral health (BH) parity statutes and extends state BH parity protections to short-term limited duration medical plans and student health plans
- ESHB 2642 (Chap. 345, Laws of 2020): Restricts prior authorization for first days of withdrawal management (detox) services and inpatient SUD treatment

Market Conduct Authority

Select Initial Impressions of Market Scans

- Differences in:
  - Provider credentialing requirements
  - Provider network adequacy monitoring
  - Provider rate setting methodologies
- Lack of clarity regarding assurance of parity compliance across carriers and delegated entities
- Network provider claims indicate that few providers serve five or more plan enrollees:
  - 50-90% of network providers saw fewer than 5 plan enrollees over a 6-month period in 2018
- Provider reimbursement:
  - Relative to national Medicare fee schedule amounts, on average across carriers, behavioral health providers are reimbursed at lower rates than medical/surgical physicians



National Association of Insurance Commissioners

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) (B) WORKING GROUP

Kana Enomoto

Former Acting Administrator for SAMHSA and Former Senior Advisor to the Surgeon General

McKinsey & Company

Unlocking whole person care through behavioral health

Kana Enomoto

10 December 2020

BIPARTISAN POLICY CENTER

The growing burden from behavioral health conditions has caused significant strain on American lives and livelihoods

~1.1 billion
people worldwide experience behavioral health conditions[1]

$900 billion
cost to the US economy annually[2]

28%
reduction in net family income by age 50 for individuals who have experienced mental disorders as a child[3]

60%
of healthcare spend can be attributed to the 23% of the population diagnosed with behavioral health conditions[4]

50%
estimated increase in the prevalence of BH conditions due to the impact of COVID-19[5]

1. IHME Disease Burden Database 2017
2. McKinsey Global Institute Prioritizing Health, 2020
3. Goodman, Proceedings of the National Academy of Sciences of the United States of America, 2011
4. McKinsey Returning to Resilience, 2020.
5. McKinsey Understanding the hidden costs of COVID-19's potential impact on healthcare, 2020.

The behavioral health system struggles to meet the quadruple aim

Access to treatment

70%

of US counties had no child psychiatrists in 2007… or in 2016[1]

25 days

average wait for psychiatry appointments for new patients[2]

Affordability of care

#1

barrier to obtaining care as ranked by those seeking behavioral health services[3]

$1,242

higher annual out of pocket spend for out of network care for those with drug use disorder vs. those with diabetes[4]

Quality of care

10%

of preschoolers with ADHD / hyperactivity receive care that is guideline-concordant[5]

8%

of medical schools have a required course on addiction medicine[6]

Experience and societal attitudes

33%

of Americans say they are scared by people with mental disorders[7]

37%

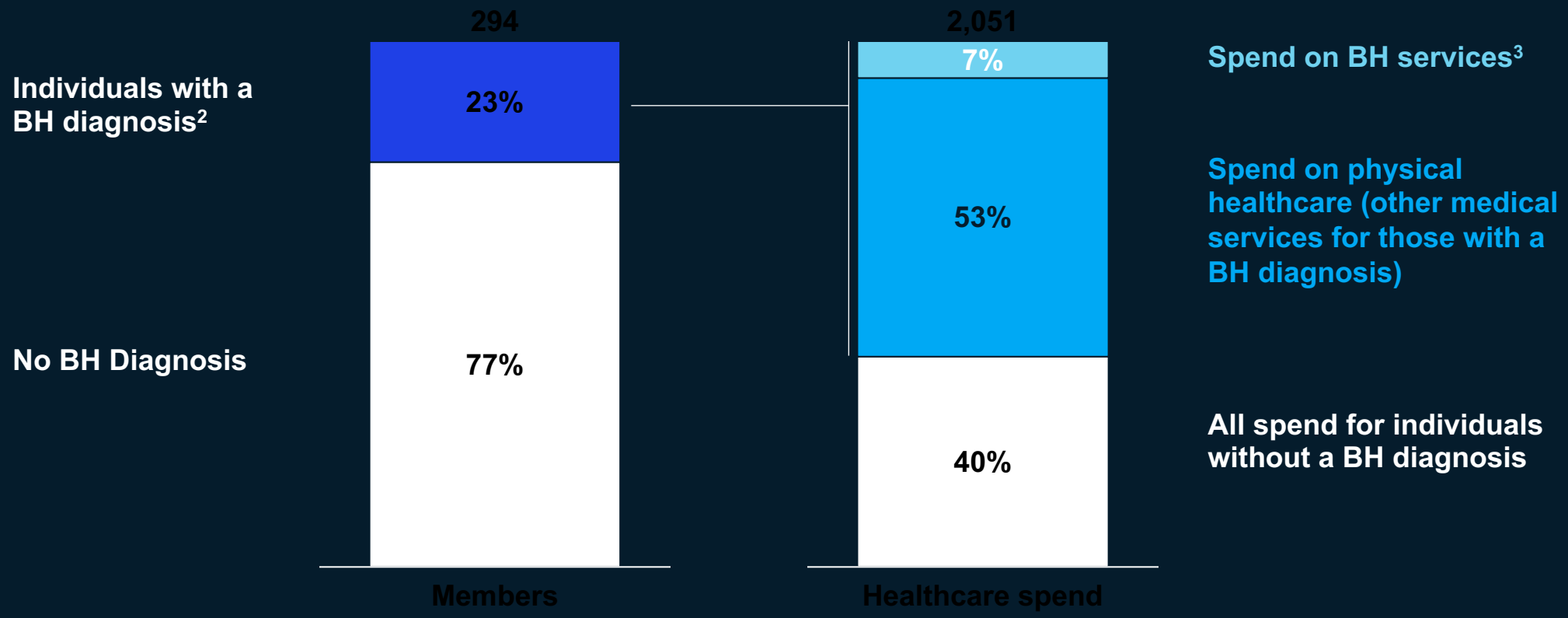
of Americans view opioid use disorder as a personal weakness and not a disease[8]

1. American Academy of Pediatrics - Growth and Distribution of Child Psychiatrists in the United States: 2007–2016;
2. Availability of Outpatient Care From Psychiatrists, 2015
3. NSDUH, 2019;
4. Xu et al, - JAMA Open Network, 2019,
5. Variability in ADHD Care in Community-Based Pediatrics, 2014,
6. Addiction Medicine Foundation, 2018
7. APA, 2019;
8. POLITICO/Harvard T.H. Chan School of Public Health 2018

Behavioral health conditions have a significant impact on overall healthcare expenditures…

US insured population, millions

Non-consumer healthcare spending[1], $ billions



1. Payer-paid amount measures or medical and pharmacy claims (excludes copays, deductibles, or out-of-pocket payments); 2. One or more medical claims with a primary or secondary diagnosis of any behavioral health condition; 3.Includes claims with a primary diagnosis of a BH condition, as well as CPT, HCPCS, and NDC codes specific to behavioral health

Source: Medicare FFS Limited Data Set, deidentified Medicaid data, Truven MarketScan Commercial Database

Even before COVID-19, behavioral health conditions directly accounted for

~16%

of years lost to poor health and premature death in the US

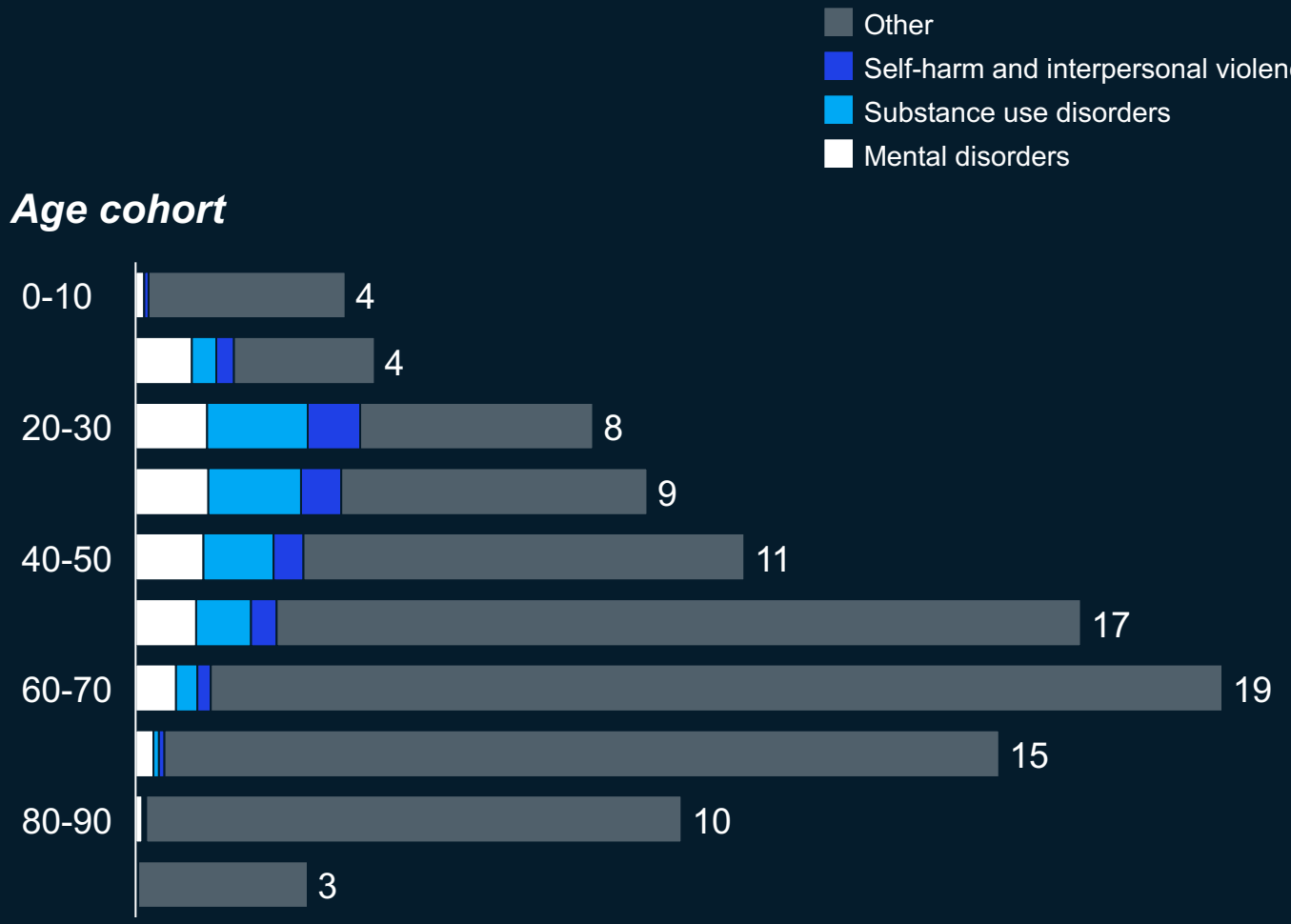
The cost to the US economy is

~$900B

annually[1]

Years lost to poor health and premature death in US in 2017[2]

Million



1. Calculated for 2017; includes cost from loss of labor supply from early deaths in 2017, poor health, and loss of productivity
2. Years lost to poor health is the sum of years lived with disability and years of life lost in 2017 due to premature death

Source: US Disease Burden Database, IHME; World Bank; McKinsey Global Institute analysis

These systemic challenges manifest themselves across the care continuum

Limited focus on **prevention and early intervention** programs for BH conditions

Low **levels of BH literacy** and lingering stigma

Low **integration** of physical health, behavioral health, and health-related basic needs

Lack of scale for **evidence-based interventions** to prevent and treat BH conditions

Lower **reimbursement** and under-funding of BH services

Shortage of **BH professionals** and physical health professionals with BH competency

These challenges result in incremental spend for individuals with behavioral health conditions

Example breakdown of incremental spend for Commercial members with behavioral health conditions relative to those without, $ PMPY

$3,000

PMPY for members with **no behavioral health conditions**

Individuals are more likely to be sick

Example: Person with an eating disorder is likely to have more physical health conditions

Individuals' care is not managed as well

Example: Person with anxiety is more likely to have preventable exacerbations and overutilization

$8,000

PMPY for members **with behavioral health conditions**

Potential savings opportunity

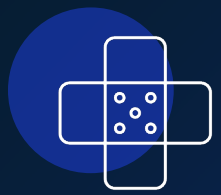
Source: McKinsey Analysis

Healthcare stakeholders have an opportunity reduce incremental disease burden and spend through six actions

Strengthen community prevention

Integrate behavioral and physical health

Leverage data and analytics



Address unmet health-related basic needs

Expand equitable access to quality care

Invest in behavioral health at parity

Taken together, these actions could reduce total US healthcare spending annually[1] by

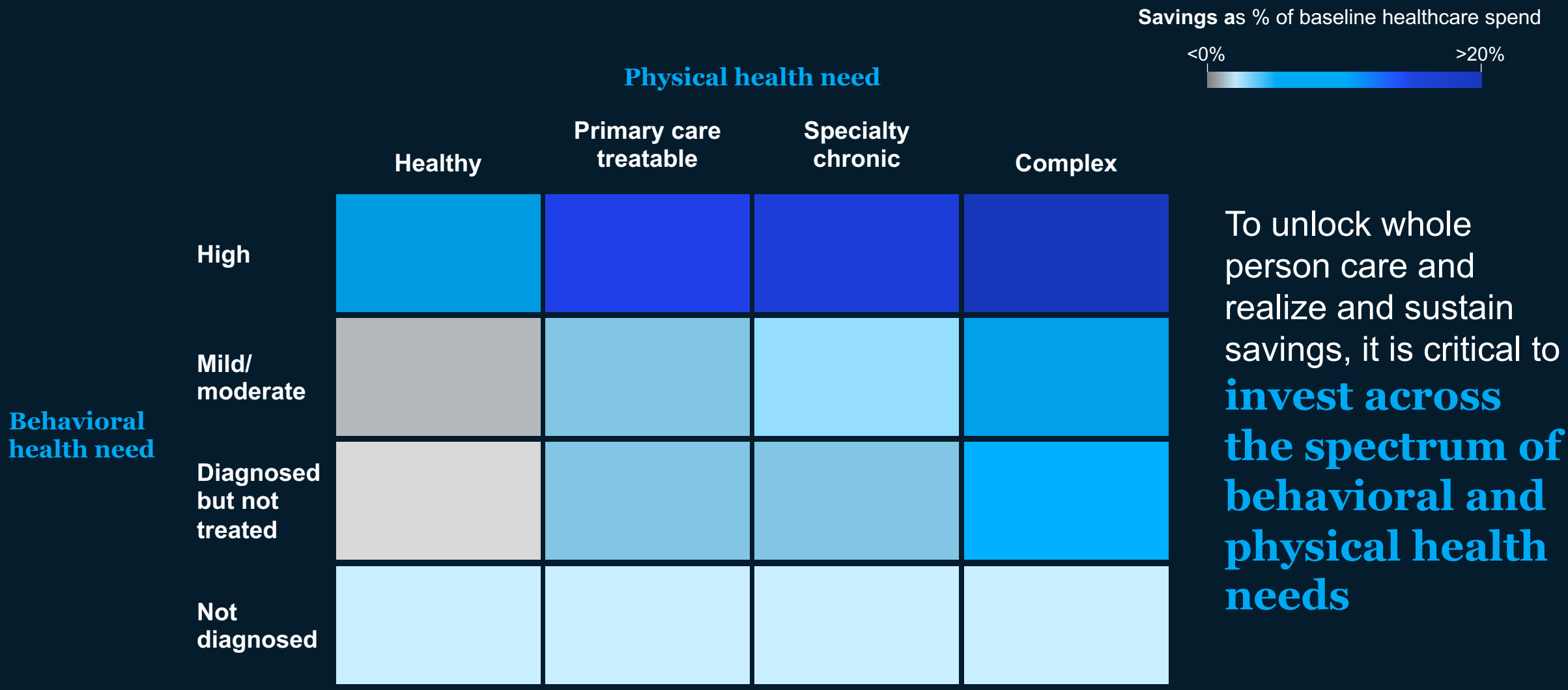
$185B

with a return of $3 for every $1 invested[2]

1. This includes Commercial, Medicare, Medicaid, and consumer spend
2. Includes investment in incremental operating and admin cost needed to implement programs that can capture cost savings.

Source: McKinsey Analysis

A holistic approach to health is key to realize full savings



To unlock whole person care and realize and sustain savings, it is critical to **invest across the spectrum of behavioral and physical health needs**

Source: McKinsey Analysis


Q + A
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