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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David Lloyd
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The Kennedy Forum

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WA Office of the Insurance Commissioner

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

<table>
<thead>
<tr>
<th>VITAL COMMUNITY CONDITIONS</th>
<th>COVERAGE</th>
<th>ENGAGEMENT</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belonging &amp; Civic Muscle</td>
<td>Affordability</td>
<td>HEALTH SYSTEMS</td>
<td>Improved community conditions</td>
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<tr>
<td>Thriving Natural World</td>
<td>Comprehensiveness</td>
<td>Primary Care / Emergency Department / Hospital</td>
<td>Increased affordability and available access to care</td>
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<tr>
<td>Reliable Transportation</td>
<td>Parity</td>
<td>WORKPLACE &amp; UNEMPLOYMENT</td>
<td>Advanced integration</td>
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<tr>
<td>Lifelong Learning</td>
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<td>Employees / Employers</td>
<td>Structures for evidence-based care</td>
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<tr>
<td>Meaningful Work &amp; Wealth</td>
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<td>Individual and family reported outcomes</td>
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<tr>
<td>Humane Housing</td>
<td></td>
<td></td>
<td>Enhanced efficiency</td>
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<tr>
<td>Basic Needs For Health &amp; Safety</td>
<td></td>
<td>JUDICIAL SYSTEM</td>
<td>Smarter use of technology</td>
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<tr>
<td></td>
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<td>Diversion / Treatment / Re-entry</td>
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<tr>
<td></td>
<td></td>
<td>EDUCATION SYSTEM</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Students / Teachers / Programs</td>
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FOCUS POPULATIONS
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
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.
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).
Senate Bill 855 – California

Landmark Legislation Enacted in California

**WHERE WE ARE**

- A near 71,000 Americans died of drug overdoses in 2019. California deaths surged nearly 18%. (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)
- 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.

**RODBLOCKS TO MENTAL HEALTH & ADDICTION CARE**

- Families are often forced to forego treatment due to huge out-of-pocket expenses. And the costs ultimately shift to taxpayers in the form of homelessness, overdoses, unemployment, and more.
- California alone could suffer over 22,500 additional deaths of despair from suicides, overdoses, alcohol poisoning, or heart disease caused by alcohol – due to COVID-19. (Source: Well Being Trust)

**WHERE WE NEED TO BE**

- SB 855 (Weintraub) 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.
- Last year in the Will 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.

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.
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**
Jane Beyer
Senior Health Policy Advisor,
Washington Office of the Insurance Commissioner
Washington State: Progress and Regulation
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
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
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
Unlocking whole person care through behavioral health

Kana Enomoto

10 December 2020
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

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

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

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

$900 billion cost to the US economy annually

~1.1 billion people worldwide experience behavioral health conditions\(^1\)

60% of healthcare spend can be attributed to the 23% of the population diagnosed with behavioral health conditions\(^4\)

28% reduction in net family income by age 50 for individuals who have experienced mental disorders as a child\(^3\)

50% estimated increase in the prevalence of BH conditions due to the impact of COVID-19\(^5\)

1. IHME Disease Burden Database 2017
The behavioral health system struggles to meet the quadruple aim

<table>
<thead>
<tr>
<th>Access to treatment</th>
<th>Affordability of care</th>
<th>Quality of care</th>
<th>Experience and societal attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>70% of US counties had no child psychiatrists in 2007… or in 2016¹</td>
<td>#1 barrier to obtaining care as ranked by those seeking behavioral health services³</td>
<td>10% of preschoolers with ADHD / hyperactivity receive care that is guideline-concordant⁵</td>
<td>33% of Americans say they are scared by people with mental disorders⁷</td>
</tr>
<tr>
<td>25 days average wait for psychiatry appointments for new patients²</td>
<td>$1,242 higher annual out of pocket spend for out of network care for those with drug use disorder vs. those with diabetes⁴</td>
<td>8% of medical schools have a required course on addiction medicine⁶</td>
<td>37% of Americans view opioid use disorder as a personal weakness and not a disease⁸</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>US insured population, millions</th>
<th>Non-consumer healthcare spending¹, $ billions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individuals with a BH diagnosis²</strong></td>
<td><strong>Spend on BH services³</strong></td>
</tr>
<tr>
<td>294</td>
<td>2051</td>
</tr>
<tr>
<td>23%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>No BH Diagnosis</strong></td>
<td><strong>Spend on physical healthcare (other medical services for those with a BH diagnosis)</strong></td>
</tr>
<tr>
<td>77%</td>
<td>53%</td>
</tr>
<tr>
<td><strong>Members</strong></td>
<td><strong>All spend for individuals without a BH diagnosis</strong></td>
</tr>
<tr>
<td>294</td>
<td>2051</td>
</tr>
<tr>
<td><strong>Healthcare spend</strong></td>
<td></td>
</tr>
<tr>
<td>77%</td>
<td>40%</td>
</tr>
</tbody>
</table>

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\(^1\).

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**Years lost to poor health and premature death in US in 2017\(^2\)**

<table>
<thead>
<tr>
<th>Age cohort</th>
<th>Other</th>
<th>Self-harm and interpersonal violence</th>
<th>Substance use disorders</th>
<th>Mental disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>20-30</td>
<td>8</td>
<td>9</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>40-50</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>60-70</td>
<td>10</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>80-90</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

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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
- 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
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- 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

- $2,000

- $3,000

- $8,000 PMPY for members with behavioral health conditions

Potential savings opportunity

Source: McKinsey Analysis
Healthcare stakeholders have an opportunity to 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.

<table>
<thead>
<tr>
<th>Behavioral health need</th>
<th>Physical health need</th>
<th>Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Healthy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care treatable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty chronic</td>
<td></td>
</tr>
<tr>
<td>Mild/moderate</td>
<td>Healthy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care treatable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty chronic</td>
<td></td>
</tr>
<tr>
<td>Diagnosed but not treated</td>
<td>Healthy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care treatable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty chronic</td>
<td></td>
</tr>
<tr>
<td>Not diagnosed</td>
<td>Healthy</td>
<td></td>
</tr>
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<td></td>
<td>Primary care treatable</td>
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Source: McKinsey Analysis
Q + A