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Written Testimony
Of
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"Meeting the Moment: Improving Access to Behavioral and Mental Health Care"

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Chairman DeSaulnier, Ranking Member Allen, and members of the Health, Employment, Labor, and Pensions Subcommittee, thank you for the opportunity to testify today on the vital topic of our nation's deepening behavioral and mental health crisis. I am Dr. Brian Smedley, and I am the Chief of Psychology in the Public Interest at the American Psychological Association (APA). APA is the nation's largest scientific and professional nonprofit membership organization representing the discipline and profession of psychology. APA has more than 122,000 members and associates who are clinicians, researchers, educators, consultants, and students. Through the application of psychological science and practice, our association's mission is to make a positive impact on critical societal issues.

In earlier testimony before Congress this year, APA described what we are facing as a "syndemic," wherein the COVID-19 pandemic is both fueled by and worsening pre-existing socioeconomic inequality. In other words, this pandemic spreads more rapidly because of social inequality and injustice, which contributes to disease clustering among those already at higher risk for poor health, which in turn multiplies the disease burden on these already-disadvantaged populations.

The mental and behavioral health toll of the pandemic is showing a similar pattern: greater impacts and higher levels of risk for certain populations, within a broader context of population-wide effects

illustrating the need for a much stronger mental health and substance use disorder treatment system that everyone can depend on. With both mental health and substance use disorders and with COVID, the risks, burdens, experiences, and outcomes have proven to vary widely across different communities. Survey data from the Centers for Disease Control and Prevention (CDC) from last June found that Black, Hispanic, and American Indian or Alaska native, Native Hawaiian or Pacific Islander respondents were significantly more likely than White respondents to report experiencing one or more adverse mental or behavioral health symptoms.[i] Although suicide rates appear to have fallen over the past year,[ii] that same survey found that Black and Hispanic respondents reported having seriously considered suicide in the previous month at roughly twice the rate of White respondents. This illustrates the need to address not just the disease itself, but also the social determinants of health. Members of racial and ethnic minorities are substantially more likely to report stress and worry about housing instability or inability to pay rent, and about having enough food to put on the table.[iii]

It must also be emphasized that because of the stress, fear, anxiety, and treatment disruptions caused by COVID-19, we are falling further behind in addressing the public health emergency that was getting much attention before the COVID-19 pandemic—the drug overdose epidemic. The CDC projects that there were more than 88,000 drug overdose deaths over the previous 12 months ending in August of 2020, an astounding 26.8% increase over the August 2019 figure.[iv] The nation will likely have experienced a drug overdose death toll of more than 100,000 Americans over the course of 2020. The CDC's data also shows that while opioids, and especially fentanyl, continue to account for the bulk of overdose deaths, overdose deaths associated with the use of psychostimulants such as methamphetamine increased by 46% over the previous year. Even before COVID-19, data showed that methamphetamine and other psychostimulant overdose deaths were occurring in the American Indian/Alaska Native population at more than twice the rate of other racial groups.[v]

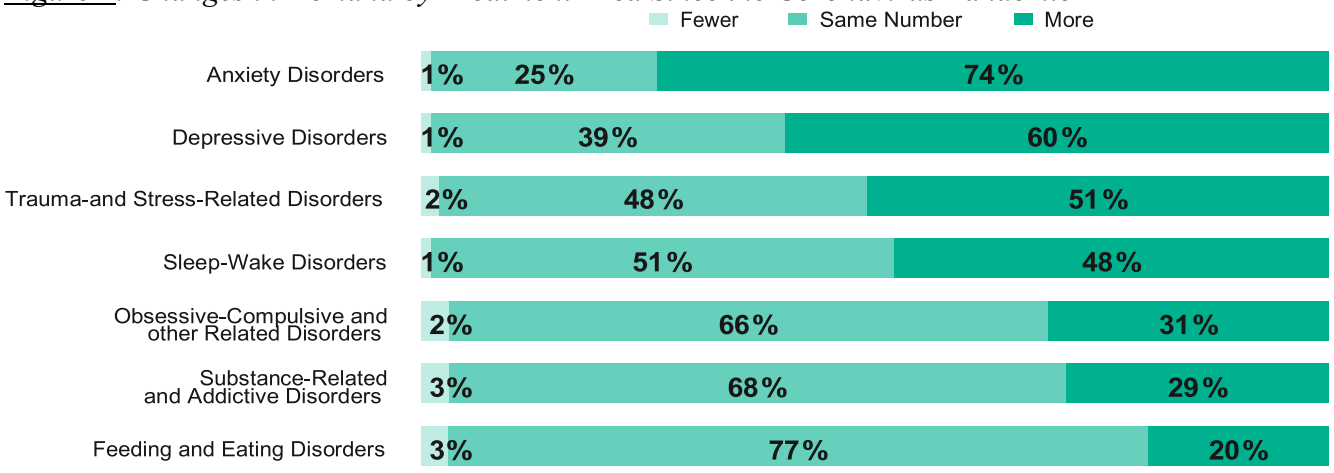
A population health approach addressing the needs of the entire population, including at-risk subgroups, is integral to addressing the mental health and substance use treatment needs heightened by the COVID-19 pandemic. My testimony today will focus on both the broader mental health impact of the COVID-19 pandemic, as well as how it is highlighting and exacerbating long-standing mental health disparities amongst disproportionately affected communities.

Overall Mental and Behavioral Health Impact of the COVID-19 Pandemic

Ample research demonstrates that the pandemic caused greater levels of stress, anxiety, depression, and trauma. According to APA's latest *Stress in America Survey*, 84% of U.S. adults reported feeling at least one emotion—such as anxiety, sadness, and anger—associated with prolonged stress within the previous two weeks. The COVID-19 pandemic was reported among the top sources of this stress.[vi] These survey results track other research showing sharp increases in reported symptoms of mental disorders[vii] and damage to social determinants of health.

Today, most of our member-clinicians continue to see an increase in patient demand for treatment of anxiety disorders (74%), depressive disorders (60%), and stress or trauma disorders (48%) than before COVID-19 (Fig. 1).

Figure 1: Changes in Demand by Treatment Area Since the Coronavirus Pandemic[viii]



The impact of the pandemic on Americans' collective mental health is highly individualized, particularly as COVID-19 has affected many communities in different ways. As an example, unpaid adult caregivers reported one or more adverse mental or behavioral health impacts at twice the rate as non-caregivers, were five times as likely to have started or increased substance use in an effort to cope with the pandemic, and were almost nine times as likely to have seriously considered suicide in the last month as non-caregivers. [i] This illustrates that there are several ways the pandemic can negatively affect an individual's mental health. The financial and economic impact of COVID-19 is a primary source of stress, with over a third of adults reporting difficulty paying for a basic living expense—such as housing, food, or utilities—within the past three months, and more than four in ten adults reporting a decrease in income or a job loss.[ix]

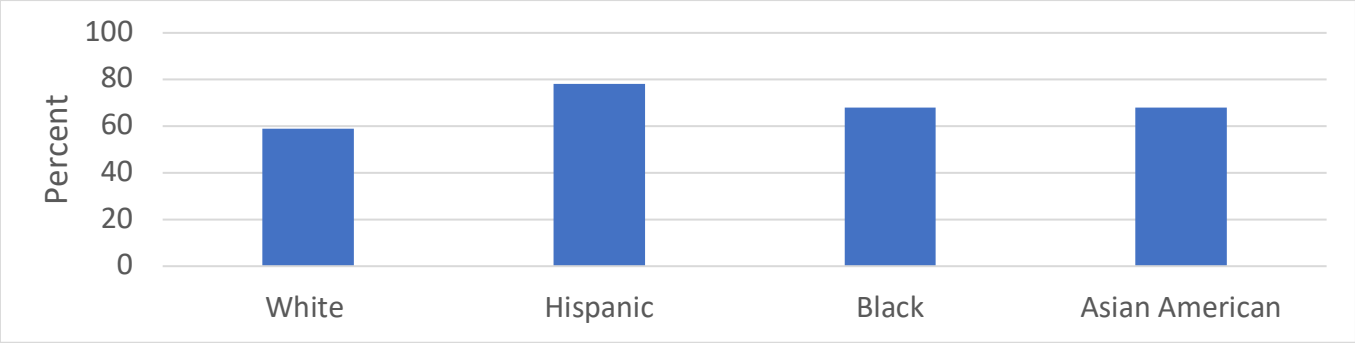
Another contributing factor is the social isolation and loneliness resulting from compliance with the public health measures, including social distancing and "stay at home" orders, necessary to control the spread of the virus. Psychologists led research on the effects of social isolation and loneliness, which were gaining recognition as a critical public health issue even before the spread of COVID-19. While physical distancing, mask-wearing, and "stay at home" orders are, and continue to be, vital tools to combat the spread of the virus, research demonstrates a link between prolonged social isolation and loneliness to both poor mental and physical health.[x] A recent tracking poll conducted shortly after many states issued COVID-related stay-at-home orders shows that individuals were more likely to report negative mental health effects from the pandemic.[xi]

COVID-19, Mental Health, and Health Equity

The impact of COVID-19 on mental health has been especially prominent in BIPOC communities of color that are also experiencing disproportionately high rates of COVID-19 cases and deaths, as well

as many of the underlying sources of stress and trauma identified above.[xii] Black and Hispanic adults are more likely than White adults to report symptoms of anxiety and/or depressive disorder during the pandemic.[xiii] BIPOC communities are also experiencing an adverse financial impact due to the pandemic.[xiv] Even in the early months of the pandemic, over 40% of Americans reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder, depressive disorder, stressor-related disorder, or substance use disorder, with significantly higher rates amongst Black and Latino communities.[xv] Black, Hispanic, and Asian-American communities are also more likely to report fear of contracting the virus itself as a source of stress (Fig. 2).[xvi] According to data collected from Mental Health America's Online Screening Program, between January and September of 2020 Native American screeners reported the highest increases in rates of depression and suicidal ideation.[xvii]

Fig. 2: Percentage of U.S. Adults Reporting Fear of Contracting Virus is a Significant Source of Stress



The pandemic did not create these disparate impacts. Instead, it exacerbated preexisting inequities in the social determinants of health that affect these groups, which in turn influence a broad array of health and quality-of-life outcomes and risks. In particular, the pandemic has highlighted long-standing systemic health and social inequities that put many racial and ethnic minorities at increased risk of contracting COVID-19 and lessening the likelihood of recovery from the virus.[xviii] Social and economic inequality, racism, discrimination, and stigma are at the root of the differences we continue to see among racial and

ethnic minorities. Even when these groups can access care, factors such as providers' implicit bias may result in inequitable health outcomes.

People with disabilities are another group facing unique stressors and challenges during the COVID-19 pandemic that can affect their mental health. Research on past pandemics shows that individuals with disabilities find it difficult to access critical medical supplies as resources become scarce.[xix] Furthermore, policies around rationing medical care can intensify discriminatory attitudes towards disabled individuals during times of crisis, which can increase anxiety about getting sick and requiring medical care.[xx]

Although research on the effect of the COVID-19 pandemic and public health responses on patients with pre-existing mental disorders is scarce, some patients are reporting increased symptoms or manifestations of mental or behavioral health disorders.[xxi] One study of patients with eating disorders found that 37.5% reported a worsening of their symptoms during the pandemic, with 56.2% reporting increased anxiety.[xxii] The study's authors suggest that limitations on fitness activities during quarantine, isolation and loneliness, and increased use of social media could be contributing factors. Notably, APA's most recent *Stress in America* report found that more than 60% of Americans surveyed reported undesired weight gain or loss.[vi] Another survey of patients with preexisting mental disorders receiving outpatient treatment found that roughly one in five reported a deterioration of their mental health related to the pandemic, with a similar proportion reporting being unable to receive routine care due to suspension of hospital visits, and of reducing or stopping their use of prescribed medications because of difficulty accessing prescriptions. [xxiii]

Children and Young Adults

APA's October 2020 *Stress in America* report found that Generation Z (defined as those between the ages of 18 and 23) reported the highest stress level of any demographic group, and that reported stress level generally declined from younger to older age groups. Children remain particularly vulnerable to the mental health impact of the crisis, as the proportion of children's emergency department visits attributable to mental health continues to rise throughout the pandemic and significantly outpaces its proportion in 2019.[xxiv] There is some evidence showing higher rates of distraction, irritability, and fear among children, with younger children being more likely to exhibit these behaviors.[xxv] In a June 2020 survey, nearly a third of parents reported that their child had experienced some degree of harm to their emotional or mental health.[xxvi] As with adults, substance use among adolescents remains a concern, as there is some evidence of rising rates of solitary substance use amongst adolescents.[xxvii]

This population is of concern not only because of their higher vulnerability to stress, but also because of the increased risk they will be impacted by adverse childhood experiences (ACEs), including various forms of abuse, neglect, and household dysfunction. More than three-quarters of child abuse and neglect is perpetrated by parents, who as a group are increasingly socially isolated, economically stressed, and engaging in substance use during the pandemic.[xxviii]

Frontline health care workers

Our nation must invest in programs that support critical essential workers who have been on the frontlines of the pandemic and in many cases are suffering from PTSD, depression, anxiety, sleep disorders and burnout. The mental health impact of this pandemic on frontline healthcare workers is well-documented, with significantly higher levels of depression, anxiety, and stress noted among many professions.[xxix] According to a Kaiser Family Foundation/Washington Post Survey, 62% of frontline

healthcare workers say that worry or stress related to COVID-19 has a negative impact on their mental health. In addition, 13% of health care workers said they have received mental health services or medication specifically due to worry or stress related to COVID-19, and an additional one in five (18%) said they thought they might need such services but did not get them.[xxx] [xxxi] Roughly 80% of graduate-level psychology trainees and early-career psychologists were also highly likely to report stress from either the financial or career impact of COVID-19 (such as greater levels of student loan debt, limited employment, or extending the time needed to complete in graduate school due to disruptions in training), or the psychological stress or workload of COVID-19 and expectations regarding maintaining quality of the services they provide. [xxxii]

Strengthening Enforcement of Mental Health Parity

APA believes that an essential policy response to help meet the increased demand for mental health services is to provide more robust enforcement of federal mental health parity law. Mental health patients and providers had high hopes that the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) would effectively address inequities in access to mental health and substance use disorder treatment.

Although the law has helped improve access to behavioral health services somewhat, pervasive parity oversight and compliance issues remain, as shown by a major analysis by the Milliman consulting agency,[xxxiii] and as described by complaints APA receives regularly from its members. MHPAEA's requirements on health plan coverage of behavioral healthcare fall into two categories: quantitative limits (such as the number of outpatient visits or days of inpatient treatment covered, copayment requirements, and deductibles) on coverage, and non-quantitative (NQTL) treatment limits (such as the medical management standards used, pre-authorization requirements for coverage of services, and the adequacy

and accessibility of the plan's network of providers). MHPAEA prohibits plans from applying either quantitative or non-quantitative treatment limits on coverage of mental health and substance use disorder services that are more restrictive than the predominant corresponding limits it uses for substantially all medical/surgical benefits. Milliman's analysis found that patients were five times more likely to seek office visits to out-of-network behavioral healthcare providers than visits to out-of-network primary care providers, strongly suggesting that health plans did not have adequate networks of behavioral healthcare providers. Milliman also found that medical/surgical providers received in-network reimbursement rates that were 18-21% higher than reimbursement rates for in-network behavioral health providers, relative to Medicare reimbursement rates for their services.

Three key factors hamper the effectiveness of MHPAEA in establishing adequate access to necessary services: (1) The need for stronger federal enforcement of self-insured health plans; (2) The lack of federal enforcement as a backup to state oversight of fully-insured health plans; and (3) The ability of state government employee health plans to opt-out of parity requirements.

Let me first explain the parity enforcement scheme set up by MHPAEA. For fully insured health insurance offered by employers, state insurance commissioners have primary enforcement authority, and HHS has secondary enforcement authority, as established under the Public Health Service Act (PHSA). Roughly half of Americans with employer-provided health insurance have this type of coverage. For self-insured health plans established under the Employee Retirement and Income Security Act (ERISA), the Department of Labor has primary enforcement authority.

While the Department of Labor (DOL) is the primary federal MHPAEA enforcement agency. DOL investigated and closed 180 parity complaints last year, HHS only resolved three complaints. DOL's MHPAEA enforcement is carried out by its staff at the Employee Benefits Security Administration (EBSA), which relies on approximately 350 investigators to review the compliance of roughly 2.5 million

private employment-based group health plans—a ratio of more than 7,000 health plans per investigator.[xxxiv] Although the agency needs more resources, its enforcement authority would be significantly strengthened by Congressman Donald Norcross's "Parity Enforcement Act of 2021," H.R. 1364, which would strengthen DOL's enforcement authority by giving DOL the authority to levy civil fines. The Parity Enforcement Act is strongly supported by APA, the Kennedy Forum, the American Society of Addiction Medicine (ASAM), and the Mental Health Liaison Group

The second issue is that HHS interprets its secondary enforcement authority as allowing it to intervene *only* if a state is substantially failing to enforce *all* of the insurance requirements established under the PHSA. Consequently, HHS is only enforcing MHPAEA compliance in a handful of states. APA has submitted comments to the agency on this issue.[xxxv] Consequently, in the vast majority of states HHS does not enforce critical but very complex compliance issues, such as the adequacy of an insurer's provider network, even if the state insurance commissioner lacks the resources, expertise, or interest in addressing this issue.

The third issue I raise concerns MHPAEA's permission for state employee health plans to opt-out of extending the law's protections to their state workers. Large numbers of state employee health plans have opted out of MHPAEA, which means that although many state employees—including teachers, police and firefighters—are essential, frontline workers directly affected by COVID and its mental health impacts, they are likely to be denied the same federal mental and behavioral health insurance protections in place for the people they serve. Congress should close this unjustified loophole and remove the option for state employee plans to decide that their state employees do not deserve MHPAEA protections.

Stronger MHPAEA enforcement and wider application of its requirements are key to achieving the law's potential. To provide greater enforcement resources and cover the expanded federal enforcement that these bills would create, APA supports a $25 million increase in funding for MHPAEA enforcement

work by EBSA within the Department of Labor, and for MHPAEA enforcement at HHS, a $10 million increase in funding for the Center for Medicaid and CHIP Services (CMCS) and a $5 million increase for the Center for Consumer Information and Insurance Oversight (CCIIO).

Extend Equitable Access to Telehealth Services

We would also like to note the critical role that telehealth services, including those furnished via an audio-only communication, continue to play in this pandemic to both broadly meet the expanded demand for mental and behavioral services and to help remedy long-standing disparities in access to these services. Audio-only services are a critical (and often the only) link to mental and behavioral health services for many individuals and communities that are less likely to have reliable access to technological training or broadband technology—including, but not limited to, older adults, individuals with disabilities, people in rural and frontier areas, lower-income families, and racial and ethnic minority communities.

However, audio-only telehealth coverage under Medicare is currently slated to end at the end of the COVID-19 PHE, at which point many of the communities who gained first-time access to mental and behavioral health services during the pandemic will suddenly lose that access. We hope members of this Subcommittee will support efforts to help avoid this "access cliff" by permanently allowing Medicare beneficiaries to receive essential mental and behavioral health services by audio-only telehealth.

Furthermore, during the COVID-19 pandemic, psychologists and other behavioral health providers found that mental health and substance use disorder services provided by telehealth for patients in self-insured ERISA plans and private health insurers are routinely reimbursed at a lower rate than for in-person care, and there are more restrictive barriers to coverage for telehealth services than in-person care. This is particularly important because most Americans have health care coverage through their employers.

The bipartisan Tele-Mental Health Improvement Act (H.R. 2264), sponsored by Representatives David Trone and Brian Fitzpatrick, would help support behavioral health providers and their patients by requiring these plans—during and shortly after the current public health emergency—to reimburse for tele-behavioral health services, including those services furnished via audio-only communication, at the same rate as in-person services, if telehealth for those services would otherwise be covered. Additionally, it would prevent such plans from imposing more restrictive barriers to coverage for telehealth services than in-person services.

I'd like to close by talking about something more positive, which is resilience. Resilience skills can be learned, and psychologists led the development of effective interventions, such as Psychological First Aid and Skills for Psychological Recovery, which are being used with frontline health care workers, first responders, and in hospital systems to give those bearing the brunt of this crisis the support they need. These services are important and need to be made more widely available, but we also need to think about community resilience. Social support (or lack thereof) is one of the strongest predictors of the development of post-traumatic stress disorder (PTSD) after a traumatic event.[xxxvi, xxxvii] The mental and physical suffering we are experiencing presents us with an opportunity, if not an obligation, to come together as a nation and in our communities to ensure that the most vulnerable among us get the help they need, and to build the social capital that will help us better weather the storms to come.

I am deeply grateful to the Subcommittee for this opportunity to testify today and look forward to further conversations with you on strategies to address the long-term mental health impact of this pandemic in an equitable manner.

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