July 27, 2021

The Honorable Senator Brendan P. Crighton, Chair
Joint Committee on Financial Services
State House Room 520
Boston, MA 02133

The Honorable Representative James M. Murphy, Chair
Joint Committee on Financial Services
State House Room 254
Boston, MA 02133

In Support of

H1062/S646: An Act for supportive care for serious mental illness

H1041/S674: An Act relative to mental health parity implementation

S645: An Act for Medical Necessity Fairness

H1039/S636: An Act providing continuity of care for mental health treatment

Dear Senator Crighton, Representative Murphy, and Members of the Financial Services Committee:

Thank you for the opportunity to submit testimony on this important issue on behalf of the National Alliance on Mental Illness of Massachusetts (NAMI Massachusetts).

NAMI Mass is a grassroots organization, and our members are individuals with mental health conditions, their family members, and caregivers. One in five adults experience a mental illness, that's almost 44 million adults each year. One in 25 adults live with a serious mental illness. As NAMI members and families, we are often the people on the front lines of dealing with our mental health system and encountering the barriers to accessing mental health services and prescription medications. All too often, evidence-based practices for individuals with serious mental illness are not covered by commercial insurance.

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Support for H1062/S646, *An Act for supportive care for serious mental illness.*

Psychosis typically onsets in teenagers and young adults aged 16-22. When young people experience a psychotic episode (schizophrenia, bipolar or schizoaffective disorder), they are often hospitalized in acute crisis and given large doses of medication to be stabilized.

Once discharged, these individuals and their families must navigate their illness and find a path to recovery without the support of a dedicated care team. Although they are told to go to an outpatient clinic some days later, most are unable do that without support. These young people are disoriented, overwhelmed and soon feel hopeless about managing their care and navigating through a fragmented care system on their own. Without a treatment team or a care plan in place, many individuals cycle in and out of the hospital from crisis to crisis. Our NAMI Mass family members are left to watch helplessly as their child suffers without adequate care, losing more ground with each episode of illness. I have personally experienced this with my son and have seen the permanent, detrimental effects of repeated hospitalizations. One summer, my son cycled in and out of the hospital every single week in July and August. Our medical system does not operate in this way for serious physical illnesses such as cancer, diabetes or a heart attack. All of these illnesses provide follow up, supportive care to ensure an individual has the best possible outcome and focuses on those supports to avoid repeated hospitalizations.

When young people cannot access care as dependents on their parents' health insurance coverage, they end up getting treatment in taxpayer-funded programs usually after a substantial delay. As they live with untreated psychosis, they often lose their community, developmental and economic supports – friends, school, jobs – and consequently experience interactions with law enforcement, incarceration, homelessness, and increased utilization of social services. Not only do these interactions deplete state and local budgets, but they also result in a deterioration of the individual's condition, creates functional disability, and necessitates more intensive treatment to achieve recovery. The longer these young people go without adequate treatment, the more likely they are to be chronically unemployed, have comorbid medical conditions, lose cognitive capabilities, and be enrolled in Medicaid and disability programs. This all comes at a cost to taxpayers that could have been avoided if health insurers were required to cover these comprehensive treatment programs at the onset of a crisis.

The ACA requires health insurers to cover dependents until age 26, during the crucial period when most first episodes of psychosis onset. In the past, commercial insurers could effectively move individuals with serious mental illness directly onto the government-funded insurance plans (at taxpayer expense), avoiding the possibility of providing available evidence-based treatments. Typically, when a child is enrolled in a parents' health plan and becomes gravely ill, insurance covers all of the necessary and evidence-based components of care. However, this is not the case for serious and disabling mental health conditions. Despite mental health parity laws, some of the most effective parts of care, those that ensure long term recovery and mitigate morbidity and mortality, are simply not covered. Would we find it acceptable if an insurer covered surgical treatment for children with cancer, but not chemotherapy and

radiation? Illinois[1] recently passed legislation that requires commercial insurance to cover both CSC programs and ACT. Other states around the country have filed legislation similar to this bill in Massachusetts.

The CSC and ACT programs, when achieving fidelity to standards as required by this legislation, have years of research demonstrating their success. Recent programs are consistently and effectively incorporating person-centered techniques including Open Dialogue and incorporating certified peer support specialists into the multi-disciplinary team. These programs meet individuals where they are, literally, be it in their home or a Starbucks. The team focuses on the supports the individual wants and ensures their goals are the focus of decision making. These are key components to helping each person build their own recovery toolkit which includes approaches to maintaining recovery and seeking assistance early when necessary.

Beyond having a much better outcome for the individual, providing CSC helps reduce the overall cost burden on insurers. Individuals with psychosis are high utilizers of health care benefits. Average excess medical costs for individuals with serious mental illness (SMI) annually are ~$10,400.[2] In addition to the cost of hospitalization, individuals who have been hospitalized typically incur $22,704 more than those with SMI who are not hospitalized.[3] Employers may not realize that their employees who are caregiving for someone with SMI have a higher rate of productivity loss (7.7%) than all other types of caregiving (3.7%)[4]. In addition, research shows that "ACT is more cost-effective than brokered approaches"[5] meaning separate programs cobbled together to provide these services. Research shows that "ACT services are justified from an economic point of view to the extent that they generate more benefits per dollar than alternative programs." [6] Here in Massachusetts, the PACT program at McLean, established in 2017, reports an average decrease in hospitalization from an average of two hospitalizations per year before PACT, to 0.7% per year in PACT. In addition, those hospitals stays are

[1] http://www.ilga.gov/legislation/101/HB/PDF/10100HB2572lv.pdf

[2] Cloutier, M. & Aigbogun, M. & Guerin, A. et al (2016). The Economic Burden of Schizophrenia in the United States in 2013. The Journal of Clinical Psychiatry. 77. 10.4088/JCP.15m10278.

[3] Zhu, B. & Ascher-Svanum, H. & Faries, D. et al (2008). Costs of treating patients with schizophrenia who have illness-related crisis events. BMC Psychiatry. https://doi.org/10.1186/1471-244X-8-72

[4] Lerner, D., Benson, C., Chang, H., et al (2017) *Measuring the Work Impact of Caregiving for Individuals With Schizophrenia and/or Schizoaffective Disorder With the Caregiver Work Limitations Questionnaire (WLQ).* Journal of Occupational and Environmental Medicine: October 2017 - Volume 59 - Issue 10 - p 1016

[5] Latimer, E. (2005) *Economic considerations associated with assertive community treatment and supported employment for people with severe mental illness,* J Psychiatry Neurosci. 2005 Sep; 30(5): 355–359.

[6] Bond, G.R., Drake, R.E., Mueser, K.T. *et al.* Assertive Community Treatment for People with Severe Mental Illness. *Dis-Manage-Health-Outcomes* **9,** 141–159 (2001). https://doi.org/10.2165/00115677-200109030-00003

shorter, as the PACT team works with the hospital on the treatment plan and the individual can be quickly discharged back to PACT. [7]

Expanding coverage by commercial insurance carriers to include evidenced-based treatments for individuals dealing with psychotic illnesses is shown to advance recovery and improve quality of life at less cost to insurers than the current practice of paying only for acute care. Delaying this necessary care until after age 26 when the individual will pass onto the public sector-funded programs is both cruel and not cost effective. Insurers are passing the cost of treating psychosis to the taxpayer, but they are also delaying appropriate care for these young people. At NAMI Massachusetts, we are all too familiar with the trauma of ineffective treatment and unnecessary barriers to recovery.

For the wellbeing of our young people in the Commonwealth dealing with serious mental illness, we urge you to report favorably on H1062/S646 to provide the supportive care our loved ones and family members deserve.

Support for H1041/S674: *An Act relative to mental health parity implementation*

Although there have been federal and state parity laws for over a decade, denial rates for mental health claims still far outweigh the number of denials for physical health claims. In a 2019 court decision in California, the judge found that United Behavioral Health (which is often known as Optum and is one of the largest behavioral health carve out insurers in the country) had a structural conflict of interest in applying its own restrictive coverage rules because it felt pressure to keep benefit expenses down. In other words, Optum systematically denied covered services to both adults and children in order to ensure their bottom line. The Wit vs. UBH case demonstrated that there are tragic consequences to these business decisions by insurers who violate the parity law. As reported by the NY Times: "One of the plaintiffs in the case said in a filing <that> her son, who struggled with substance abuse, died after he was forced to leave a residential treatment facility when the insurer denied coverage."[8]

That insurance companies can continue these business practices with minimal repercussions and no incentives to change their business model reflects the state of enforcement of our existing parity laws. Much of the enforcement until now has required insured individuals to understand when they have had a parity violation. Asking people experiencing a mental health crisis (be it themselves or a family member) to navigate through the complexity of the parity law is patently unfair and unreasonable.

When insurance carriers do not provide coverage for mental health services on a par with physical health care, they are discriminating against those with a mental health condition. *The denial and reimbursement*

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[7] Contacts at McLean Hospital: Chloe Pedalino, Program Director https://www.mcleanhospital.org/treatment/pact

[8] https://www.nytimes.com/2019/03/05/health/unitedhealth-mental-health-parity.html

policies of insurers drive hundreds of business decisions by providers that lead to fewer beds, fewer mental health providers and numerous barriers to care.

The mental health parity bills before you – S675 and H1041 – will provide stronger, more pro-active oversight by state regulators to help us investigate illegal practices and eliminate any unfair and potentially illegal barriers to care. Stronger, more effective enforcement of parity rights will help people access the behavioral health care that they need without becoming legal parity experts themselves.

For these reasons, NAMI Massachusetts strongly supports these bills and we urge you to consider these bills for a favorable report out of your committee.

Support for S645: *An Act for Medical Necessity Fairness*

As mentioned above, the Wit decision in 2019, highlighted the need to address how insurance carriers determine medical necessity. S645 requires that insurance plans follow existing established independent guidelines for determining medical necessity. The medical necessity criteria have long been a technique used by insurers to systematically deny benefits to their plan members while ignoring parity requirements. Establishing criteria that is based on the medical needs of the individual, rather than the perceived financial considerations of the insurer, will reduce those denials and barriers to accessing care. Insurance carriers have a long history, particularly through the use of "carve outs" of prioritizing their bottom line over the needs of the individuals. S645 will establish a level playing field and will bring mental health care into alignment with both physical health care decisions and substance use care decisions.

For these reasons, NAMI Massachusetts strongly supports S645 and we urge you to consider these bills for a favorable report out of your committee.

Support for H1039/S636: *An Act providing continuity of care for mental health treatment*

As NAMI Mass members, we are sensitive to how difficult it can be to find a therapist and to build a trusting, supportive relationship. It is often a long journey to finding that therapist and it is incredibly disruptive when that relationship is interrupted due to a change in insurance circumstances. While it may be common and even accepted to switch a PCP when they become out-of-network, it is an order of magnitude more difficult to replace a good working relationship with a therapist.

While this has always been a concern, with the amount of disruption in people's lives in the last year due to COVID-19, many, many more people have moved out of their current employment, one of the most common ways a provider becomes out-of-network. We have also seen a lot of migration of insurance panels due to provider change.

Note that this bill does not cost insurance providers nor would it require raising premiums. Insurers would only pay licensed mental health care professionals the usual network per-unit reimbursement rate for the relevant service and provider type, or alternatively the median reimbursement rate if more than one rate exists. If it costs the insurer more to use a non-network provider, the insurer may require the covered person pay a higher co-payment if the insurer can provide an actuarial demonstration of those increased costs. This is a no-cost way to ensure that individuals who suddenly find themselves in an out-of-network situation during an ongoing therapeutic relationship will financially be able to continue that relationship.

For these reasons, NAMI Massachusetts strongly supports H1039/S636 and we urge you to consider these bills for a favorable report out of your committee.

We appreciate the Committee's time and attention to all these bills. Too often the barriers to accessing mental health care are related to how we have structured our financial systems for that care. These bills, taken together, will increase access and reduce financial burdens on both those who have a behavioral health condition and insurers. Our community fervently hopes you will report favorably on these bills.

Sincerely,

Monica Luke
Chair, Advocacy Committee
NAMI Massachusetts