Testimony in SUPPORT of SB 384: An Act Concerning Mental Health Parity, Data Reported By Managed Care Organizations and the All Payers Claims Database

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I am a psychiatrist training at Yale School of Medicine and I am writing in support of SB 384. As a physician, I treat patients with psychiatric illness and substance use disorders and I have the privilege of witnessing patients get well with the help of evidence-based psychiatric interventions including hospitalizations, medications, and therapy. However, these treatments are only effective when patients come to care.

One out of every 2 patients who are referred to psychiatric care do not follow through with referrals[1] and almost half of the patients who did not follow up were deterred because they couldn't afford psychiatric treatment.[2] Many assume that having private insurance makes psychiatric care affordable and accessible, but nearly 40% of privately insured patients could not afford psychiatric care.[2] A driving force of these high costs of care is that patients are unable to find an in-network psychiatric provider who will accept their insurance. This forces patients to decide between no treatment or expensive, out of network providers. Patients are much more likely to depend on expensive out of network treatment when seeking psychiatric care than when they are seeking medical and surgical care. <u>The 2017 Milliman Report revealed that Connecticut is ranked the worst state in the nation</u> for the disparity between psychiatric and medical out of network usage for patients who are privately insured. Only 3% of medical and surgical visits were out of network, while 1 out of every 3 psychiatric visits were out of network.[3] As you compare these numbers, the best explanation for these discrepancies are issues with mental health parity: insurers have not adequately developed their in-network provider lists for psychiatric care.

Ten years ago, Congress passed the Mental Health Parity and Addiction Equity Act. Some disparities have been reduced, mainly quantitative treatment limitations, such as the annual limits on the number of therapy visits, as well as higher copays and separate deductibles for psychiatric care.[4] But we still have work to do. Insurers continue to utilize non-quantitative treatment limitations (NQTLs) to disproportionately limit psychiatric care compared to medical and surgical care, capitalizing on limited government oversight and through mechanisms that are challenging to track, like those outlined above. The proposed SB 384 aims to address some of these NQTLs by holding insurance carriers accountable for complying with mental health parity legislation through data collection and analysis.

When patients with psychiatric illness come to treatment, they are in crisis and they are suffering. We talk about psychiatric and medical illness as separate entities, but this distinction is arbitrary and outdated. Psychiatric illness is as much a medical disease as heart disease. Patients with psychiatric illnesses deserve the same access to affordable and equitable care that patients with medical illnesses are provided. During times of crisis, whether the symptom is suicidal ideation or chest pain, patients' and families' immediate concerns should not be the affordability of care they are being provided. They should not be burdened with holding their insurance companies responsible for abiding by parity laws.

The Connecticut General Assembly should step in and strongly enforce mental health parity laws through bills like SB 384 to ensure that Connecticut residents have access to the psychiatric care they deserve.

1. “Transforming Mental Health Care at the Interface with General Medicine: report for the President’s Commission.” 2006.
2. National Survey on Drug Use and Health (NSDUH) 2015
3. http://www.milliman.com/NQTLDisparityAnalysis/
4. https://khn.org/news/advocates-say-mental-health-parity-law-is-not-fulfilling-its-promise/