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MENTAL HEALTH CARE

Consumers with Coverage Face Access Challenges

Statement of John E. Dicken, Director, Health Care

Chairman Wyden, Ranking Member Crapo, and Members of the Committee,

I am pleased to be here today as you examine issues related to consumer access to behavioral health services. Behavioral health conditions—which include mental health and substance use disorders—affect millions of people in the United States.¹ Additionally, the effects of the COVID-19 pandemic and related economic crisis—such as increased social isolation, stress, and unemployment—have intensified concerns that behavioral health conditions have affected even more people.

We have issued several recent reports addressing various aspects of behavioral health care in the United States. They include three reports issued since the onset of the COVID-19 pandemic that examined, among other things, ways that the pandemic affected behavioral health care.² Prior to the pandemic, we issued a report focused on state and federal oversight of behavioral health parity requirements defined in law.³ In general, federal law requires that when certain health plans offer coverage for medical and surgical treatment as well as mental health or substance use disorder treatment, the coverage for mental health and

¹For example, in 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that nearly 74 million adults in the U.S. (29 percent) were reported to have either a mental illness or a substance use disorder. See Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, (Rockville, Md.: October 2021).

²See GAO, *Behavioral Health and COVID-19: Higher-Risk Populations and Related Federal Relief Funding*, [GAO-22-104437](#) (Washington, D.C.: Dec. 10, 2021); *Behavioral Health: Patient Access, Provider Claims Payment, and Effect of COVID-19 Pandemic*, [GAO-21-437R](#) (Washington, D.C.: Mar. 31, 2021); and *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, [GAO-21-191](#) (Washington, D.C.: Nov. 30, 2020).

³See GAO, *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies*, [GAO-20-150](#) (Washington, D.C.: Dec. 13, 2019).

substance use disorder treatment may be no more restrictive than coverage for medical or surgical treatment.⁴

Today we are releasing a report entitled *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*.⁵ As the title indicates, this report focuses on consumers who have coverage for mental health care and the challenges they encounter despite having that coverage. There have been longstanding concerns in the U.S. about the accessibility of mental health services for these consumers. Although approximately 91 percent of the U.S. population is covered by public or private health plans, having such coverage does not guarantee access to mental health services. For example, a 2021 report by Mental Health America (a non-profit advocacy and research group) estimated that 54 percent of consumers covered by a health plan did not receive the mental health treatment they needed—indicating that ensuring coverage is not the same as ensuring access to mental health care.⁶

My testimony today summarizes the findings from the report released today. Accordingly, my testimony discusses

1. challenges that consumers with coverage for mental health services may experience accessing these services and
2. ongoing and planned federal efforts to address these challenges.

For this report we interviewed federal officials from the Departments of Health and Human Services (HHS) and the Department of Labor (DOL), which share responsibilities for overseeing compliance with mental health parity laws. We also interviewed representatives from 29 stakeholder organizations representing consumers, health plans, providers, insurance

⁴See the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Pub. L. No. 110-343, div. C, tit. V, sub. B, §§ 511-12, 122 Stat. 3765, 3881-93 (Oct. 3, 2008). MHPAEA was enacted in 2008 to help address discrepancies in health care coverage between mental illnesses and physical illnesses. MHPAEA both strengthened and broadened federal parity requirements established by the Mental Health Parity Act of 1996, including extending parity to cover the treatment of substance use disorders.

⁵See GAO, *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*, [GAO-22-104597](#) (Washington, D.C.: Mar. 29, 2022).

⁶M.Reinert, D. Fritze, and T. Nguyen, *The State of Mental Health in America 2022* (Alexandria, Va.: Mental Health America, 2021).

regulators, and mental health and Medicaid agencies.⁷ These included national organizations and organizations from four states—Connecticut, Oregon, South Carolina, and Wisconsin—selected based on mental health metrics and geographic variation, among other factors. GAO also reviewed relevant reports obtained from these agencies and organizations and reviewed academic and industry research focused on consumer access to mental health care. More detailed information on our objectives, scope, and methodology can be found in the issued report. Our work was performed in accordance with generally accepted government auditing standards.

Challenges Finding In-Network Providers and Navigating Plan Details

In our March 2022 report, we found that consumers experience a variety of challenges accessing mental health benefits provided under their health plans. Some of the challenges occur because of limited access to in-network providers or broader structural issues in the mental health system that make it difficult to access affordable mental health care or certain types of mental health care in a timely manner. Other challenges occur because of processes used by health plans to approve mental health treatment or limitations in services and treatments covered by some health plans—these can delay or limit the course of treatments or make treatments unavailable for certain consumers.

Limited Access to In-Network Providers and Broader Structural Issues

Stakeholders we interviewed told us that limited access to in-network providers can result in consumers seeking care from out-of-network providers, typically resulting in higher costs for the consumer, possible delays in receiving care, or difficulties in finding a provider close to home. Most of the stakeholders we interviewed told us that one factor contributing to this challenge is low reimbursement rates for mental health service providers, which many said can reduce providers' willingness to join plan networks. This point was also supported by reports and research we reviewed.⁸ The ability to develop a provider network is also exacerbated by an overall shortage in the mental health workforce. This

⁷In reporting our findings based on the testimonial evidence collected from the 29 stakeholder organizations, we generally indicate the numbers of organizations that identified specific challenges using indefinite quantifiers as defined in the issued report.

⁸For example, one study that examined provider participation in networks for plans sold on state marketplaces created by the Patient Protection and Affordable Care Act found that only 21.4 percent of mental health care providers participated in the networks compared to 45.6 percent of primary care providers. The researchers noted that relatively low reimbursement rates for mental health care could be one factor contributing to these differences. See J.M. Zhu, Y. Zhang, and D. Polsky, "Networks in ACA Marketplaces Are Narrower for Mental Health Care than for Primary Care," *Health Affairs*, vol. 36, no. 9 (2017).

shortage limits the pool of providers who could join a network and may give existing providers leverage to opt out of networks and receive higher rates for their services than those offered by the plans.

Another challenge for consumers' ability to find in-network providers is inaccurate information in health plans' provider directories. Many stakeholder organizations said that inaccurate directories could create what they referred to as a "ghost network"—in other words, providers who are listed in a directory as participating in the network, but who are either not taking new patients or are not actually in a patient's network. For example, recent studies that evaluated consumers' use of provider directories to schedule outpatient appointments with psychiatrists found that inaccurate or out-of-date information complicated consumers' ability to obtain care.⁹

Representatives from most of the stakeholder organizations we interviewed also identified structural challenges that limit the overall capacity of the mental health system as affecting covered consumers' access to care, and literature we reviewed examined some of these issues.¹⁰ For example, some of the stakeholders noted that the mental health workforce shortage makes it difficult to keep up with the demand for mental health services. Similarly, a shortage of available inpatient treatment beds limits consumers' access to the treatment they need. Some attributed this shortage to increased demand for services, budget cuts, or staffing issues—in some cases related to the COVID-19 pandemic. In addition, representatives from many of the stakeholder organizations told us that a shortage of intermediate care options, such

⁹See M. Malowney, S. Keltz, D. Fischer, and J. Boyd, "Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three U.S. Cities," *Psychiatric Services*, vol. 66, no.1 (2015): 94–96; S. Cama et al., "Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities," *International Journal of Health Services*, vol. 47, no. 4 (2017): 621–635; and M. Scheeringa, A. Singer, T. Mai, and D. Miron, "Access to Medicaid Providers: Availability of Mental Health Services for Children and Adolescents in Child Welfare in Louisiana," *Journal of Public Child Welfare*, vol. 14, no. 2 (2020): 161–173.

¹⁰For example, see, Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers* (2017), and University of Wisconsin, Population Health Institute, *2019 Wisconsin Behavioral Health Systems GAPS Report* (Madison, Wis.: Prepared for the Wisconsin Department of Health Services, 2020).

as residential treatment facilities or intensive outpatient programs, has created challenges for consumers in getting intermediate levels of care.¹¹

Representatives from several stakeholder organizations also told us that the lack of access to broadband internet services, particularly in rural areas, can limit consumers' ability to use telehealth for mental health services. This may make it more difficult to access mental health services, particularly when in-person treatment is unavailable, such as during periods of social distancing during the COVID-19 pandemic or when consumers have to travel long distances to see a provider. Despite broadband internet limitations in some areas, representatives from most stakeholder organizations we interviewed indicated that enhanced use of telehealth during the pandemic generally helped improve access to mental health care.

Plans' Administrative Approval Processes and Coverage Limitations

Stakeholders we interviewed reported that the need to obtain health plans' approval for certain mental health services, as well as other coverage limitations, can adversely affect access to mental health care. Taken together, these challenges can delay or limit the course of treatments or, in some cases, make treatments unavailable for certain consumers.

Representatives from many stakeholder organizations we interviewed specifically cited non-quantitative treatment limitations (NQTL) used by health plans—such as the need for obtaining prior authorizations—as creating delays in accessing needed treatments or limiting time spent in treatment. For example, representatives from one health system reported that some health plans are less likely to grant prior authorization for mental health hospital stays compared with medical and surgical hospital stays. Some also said plans' processes for determining whether continuing a treatment is medically necessary can limit the duration of a consumer's treatment, even if the provider does not agree that the patient is ready for discharge. In some cases, stakeholders said that health plans are applying these limits to consumers' mental health benefits in more restrictive ways than to medical and surgical benefits, which highlights

¹¹Intermediate levels of care are less intensive than inpatient care but more intensive than routine outpatient care, and may consist of acute residential treatment, partial hospitalization programs, intensive outpatient programs, and family stabilization services. Residential treatment programs may offer long-term mental health care in a structured, homelike setting, where the patient stays for the duration of the treatment. Intensive outpatient programs provide weekday treatments under which patients can return home each evening.

ongoing mental health parity issues. Some of the reports we reviewed also identified the use of NQTLs by health plans that did not comply with mental health parity standards as presenting a potential challenge to consumers in accessing mental health care.¹²

Representatives from several of the stakeholder organizations also told us that variation in the use of treatment standards can affect covered consumers' access to mental health care. Currently, there is no agreed-upon set of standards used in the U.S. to make mental health treatment decisions. The stakeholder representatives indicated that, absent such standards, it can be difficult for providers and health plans to agree on the treatment a patient may need, and some said health plans may limit a consumer's treatment options. For example, representatives from one provider told us they often feel pressured by health plans to move patients out of hospital-based services to less intensive outpatient treatment. Representatives from another provider said health plans will stop coverage of a suicidal patient's treatments once the patient is stable, even though a provider believes the patient needs continuing care.¹³

Regarding coverage limitations and restrictions, representatives from several stakeholder organizations and reports and research we reviewed identified challenges accessing mental health care faced by consumers with certain forms of coverage. For example, representatives from many of the stakeholder organizations contended that the scope of mental health services covered by Medicare and commercial plans is generally more limited than Medicaid. As a result, consumers with Medicare or commercial coverage may not have access to the range of mental health services available to consumers with Medicaid. Many stakeholder organizations cited Medicaid's coverage of crisis care and peer support

¹²For example, see, J. Volk et al., *Equal Treatment: A Review of Mental Health Parity Enforcement in California*, (California Health Care Foundation, 2020). The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California.

¹³The issues surrounding a lack of uniform standards of care, and how that can affect treatment decisions for mental health care, have been litigated in federal court. See *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2019 WL 1033730 (N.D. Cal. 2019).

as examples where the services were more comprehensive than Medicare and commercial coverage.¹⁴

Stakeholder representatives also cited challenges consumers face related to statutory coverage restrictions on federally funded programs, such as Medicare. For example, some told us that Medicare restrictions on the types of providers eligible for reimbursement, including Licensed Professional Counselors and Licensed Marriage and Family Therapists, affect access to mental health services for Medicare enrollees by limiting the pool of accessible providers. In addition, some stakeholders we spoke with highlighted the fact that Medicare has a lifetime limit for enrollees of 190 days of inpatient care in psychiatric hospitals. These stakeholders said that this limit creates barriers and disruptions to care for people with serious mental illnesses who may need more inpatient care.

Related Federal Efforts May Address Aspects of Mental Health Access Challenges

Based on our interviews with agency officials and reviews of agency documentation, we identified various ongoing or planned federal efforts to address some of the challenges consumers with coverage may experience accessing mental health care. These efforts aim to address challenges related to finding in-network providers, broader structural issues, and health plan administrative approval processes.

Addressing Limited Access to In-Network Providers. DOL and HHS are taking steps to ensure access to in-network mental health providers. For example:

- HHS' Center for Medicare & Medicaid Services requires Medicare Advantage plans to meet a number of network adequacy criteria, such as requirements for plans to demonstrate that their networks do not unduly burden beneficiaries in terms of travel time and distance to network providers or facilities, including inpatient psychiatric facility services and psychiatric services.

¹⁴According to SAMHSA, crisis services may include crisis telephone lines dispatching support based on the caller's assessed need, mobile crisis teams dispatched to the community where there is a need (i.e., not in a hospital emergency department), and crisis receiving and stabilization facilities that serve patients from all referral services. SAMHSA also defines peer support services as a range of recovery activities and interactions outside of the clinical setting between people who have shared lived experiences with a mental illness. For more information, see Substance Abuse and Mental Health Services Administration, *Crisis Service Meeting Needs, Saving Lives: National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit* (Rockville, Md.: August 2020) and *Who Are Peer Workers?* (Rockville, Md., September 2021).

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- DOL and HHS are implementing requirements for certain health plans to update and maintain provider directories.
 - The Health Resources and Services Administration within HHS manages several programs that provide funding intended to increase the mental health workforce.

Addressing Broader Structural Issues. The Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS manages several programs aimed at addressing structural issues that contribute to a lack of capacity in the mental health system. For example:

- Funding 12 grants designed to establish or expand Assertive Community Treatment programs to deliver a mix of individualized, recovery-oriented services to persons living with serious mental illness to help them successfully integrate into the community.
- Overseeing the Certified Community Behavioral Health Clinics expansion grant program. These clinics provide comprehensive, integrated mental health services, such as crisis mental health services and primary care screening and monitoring.

Addressing Issues with Health Plan Administrative Approval Processes. DOL and HHS are taking steps to enhance their oversight of the use of NQTLs by health plans—such as requirements for prior authorization—as part of their broader responsibilities to oversee compliance with mental health parity laws. These steps are being taken, in part, to meet requirements specified in the Consolidated Appropriations Act, 2021, which requires group health plans that cover both medical and surgical and mental health and substance use disorder benefits to perform and document comparative analyses of the design and application of NQTLs.¹⁵

Mr. Chairman and members of the committee, this concludes my prepared statement. I would be pleased to respond to any questions that you or other members of the committee may have at this time.

For future contacts regarding this statement, please contact John E. Dicken at (202) 512-7114 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Gerardine Brennan, Assistant Director;

¹⁵Pub. L. 116-260, § 203, 134 Stat. at 2900 (2020).

Nick Bartine, Analyst in Charge; Taylore Fox; and David Lichtenfeld made key contributions to this statement.

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