Rhode Island Psychological Association

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The Honorable Representative Susan Donovan
Chair of the House Health and Human Services Committee
82 Smith Street
Providence, RI 02903

Testimony in Support of House Bill # 5863
HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

Dear Chairman Donovan and Members of the Committee:

I am writing on behalf of the Rhode Island Psychological Association in ***support*** of *H5863 – the Health Care Accessibility and Quality Assurance Act."* Federal Mental Health Parity and Addiction Equity Act (MHPAEA, 2008)[1] and the State Mental Health Parity law, RIGL §27-38.2-1[2] require that a health insurance plan provide coverage for the treatment of mental health and substance-use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases."[3] While reimbursement for behavioral health services is required for state regulated health plans, and over the past 30 years the state and federal governments have legislated and regulated significant improvement in the coverage for these services, the reimbursement for these services by our commercial health insurance companies has not kept up with the cost of providing quality accessible care to Rhode Islanders. The *Special Legislative Commission to Study the Impact of Insurer Payments on Access to Health Care* led by Senators Miller and DiPalma in 2019-2020 identified that commercial insurance reimbursement for behavioral health services historically have been and are significantly below equivalent medical services. I am appending a *Summary of Behavioral Health Reimbursement Disparities* prepared by Rachel Soule an attorney for the American Psychological Association.[4] The insurance companies' instance on setting inadequate rates for these services creates a major barrier

[1] https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity
[2] https://webserver.rilegislature.gov//Statutes/TITLE27/27-38.2/INDEX.htm
[3] The Rhode Island Office of the Health Insurance Commissioner's Report Pursuant to *House Resolution No. 6524*, March 1, 2024
[4] Soule, R (2023) Summary of Behavioral Health Reimbursement Disparities, Unpublished Manuscript from the American Psychological Association

to Rhode Islander's ability to obtain the care they need and for which they are paying with their insurance premiums. This barrier will never be alleviated until the General Assembly takes the lead and asserts the interests of our Rhode Island community to make it possible for everyone who needs care to get it.

As described in the OHIC Commissioner's 2024 Report *Pursuant to House Resolution No. 6524* Report many Rhode Islanders have mental health and substance abuse issues, and it is hard for them to get care.[5] This is consistent with what the National Alliance of Mental Illness (NAMI) reported in 2021 that more than a quarter of people with anxiety and depression symptoms could not find treatment in Rhode Island.[6]

Despite the mental health and substance abuse service community's efforts we have never been able to meet the needs of the community for accessible services. The situation deteriorated during the COVID Pandemic, and it has not abated. Further while it's hard for inured people to find a behavioral health professional, it is even harder to find one who takes health insurance, and it is even harder than that to find one who can start new clients as promptly as they should be seen. To obtain services many people in Rhode Island pay out of pocket to get the care they need. The National Alliance on Mental Illness (NAMI) reported in 2021 that people with mental health needs are four times more likely to see a behavioral health professional who does not participate in their insurance plan's network than people seeking primary care services. In 2024 the *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue* report from the Research Triangle Internal reported that people seek services from non-network professionals 10 times as often for mental health services as they do for primary care services.[7]

Why can't people find services? There are not enough behavioral health care professionals to meet the need. We have difficulty attracting professionals to make their careers in Rhode Island. We have high quality graduate and post-graduate training programs for master's clinicians, psychiatry residents, and psychology interns and residents. Students and trainees come here to learn; and when they are done, they leave. This is particularly true for people who come from ethnically diverse backgrounds. We will serve our state best when our workforce reflects the diversity of our state's population.[8]

Why won't professionals stay here? The biggest issue is they can't earn a living here commensurate with their education (and usually high student loan debt), the cost of

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[5] https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-01/OHIC%20Report%20Pursuant%20to%20House%20Resolution%20No.%206524%20FINAL.pdf

[6] The National Alliance of Mental Illness, https://namirhodeisland.org/wp-content/uploads/sites/209/2021/06/RhodeIslandStateFactSheet.pdf

[7] Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International.

[8] McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. Health Aff (Millwood). 2008 Mar-Apr;27(2):393-403. doi: 10.1377/hlthaff.27.2.393. PMID: 18332495; PMCID: PMC3928067.

providing the services, the workload and stress they experience. They can earn more elsewhere. Insurance rates for behavioral health services have been largely stagnant throughout my career and are now so low that the cost of doing business makes it inviable to operate a practice.

This November will mark the 31st anniversary of my group practice in Barrington. During that time the Consumer Price index has more than doubled.[9] Add on top of all our expenses the cost of all the Information Technology (IT) infrastructure and services we use to serve our patients and work with insurance companies that did not exist or barely existed 30 years ago. For my practice that was an average of over $19,000 per year over the past three years above and beyond what I was paying for IT services in 1994. Those services included our electronic medical record and billing services, credit card processing, secure communications services, and other security measures that are required for us to meet government security standards. During that time the fee that Blue Cross and United HealthCare reimburse for a standard individual psychotherapy visit (CPT Code 90834) has risen 59% and 40% respectively. I have decided that it is no longer viable to continue my practice, and it's time to retire. I will close my practice at the end of the year. Still, I want all Rhode Islanders to have access to quality accessible services, and I want our local behavioral health professionals to have a future here to provide these needed services.

No matter how the reimbursement rates are calculated, we are not getting paid enough to continue to be able to provide the quality of service we want to give to Rhode Islanders in the future. The foundation of the rates starts with a committee of the American Medical Association. The General Assembly cannot do anything about that. However, the commercial insurance companies create their rate schedules based on the AMA's Current Procedural Terminology codes (CPT)[10], and that is where the General Assembly can intervene. For most local professionals and group practices there is no negotiation. The insurance companies will reflexively resist any effort to make them adapt their rates to the levels needed to support Rhode Islander's behavioral health needs properly. You, the General Assembly, can take charge and tell them they need to do this. The rate increase of H5863 is a small gesture, but it is also a message. It sets a precedent that hopefully will entice the commercial insurance companies to do better in the future. We will appreciate the gesture and that will encourage behavioral health professionals to continue to do the work we do. The reporting requirements included in this bill will help to keep state government, health care professionals and the public informed about the current status of reimbursement.

We would like to thank the sponsors for submitting this bill, and all the members of the Committee for your consideration of how we can best meet the health and behavioral health needs of our community. Your support of H5863 will help to make behavioral health services more accessible to all Rhode Islanders across our state at a time when they

[9] https://www.bls.gov/data/inflation_calculator.htm [November 1994 to February 2025: 213%]
[10] https://www.ama-assn.org/about/cpt-editorial-panel/cpt-purpose-mission

are greatly needed, and your support will help us to provide those services. Please *support* this bill. Thank you.

Sincerely,

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Summary of Behavioral Health Reimbursement Disparities
Rachael Soule, JD
American Psychological Association, 2023

Milliman is one of the most highly cited studies related to behavioral health reimbursement disparities. The study published in 2019 found that insurance coverage for MH/SUD benefits continues to be more expensive and more limited than for comparable Med/Surg benefits. Steve Melek, Stoddard Davenport & T.J. Gray, Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement, MILLIMAN (Nov. 19, 2019). The Milliman study found that disparities between private rates and Medicare for behavioral health versus physical health care have increased over time. Finding that out-of-network and low reimbursements were worse in 2017 than 2015 data.
Other statistics from the Milliman study found that:

- 17.2% of behavioral office visits were to an out-of-network provider compared to 3.2% for primary care providers and 4.3% for medical/surgical specialists, and reimbursement rates as a percentage of Medicare payments were lower for behavioral health than for primary care.
- For in-network services, significant disparities remain in reimbursement rates, with primary-care reimbursements 23.8% higher than behavioral reimbursements. Also, showing the behavioral out-of-network inpatient utilization rate rising from 5.84 to 10.38 times that of Med/Surg, and the primary-care reimbursement gap rising from 8.1% to 17.7%.
- Even in states with relatively aggressive Mental Health Parity enforcement, disparities in utilization patterns and reimbursement rates persist. In Massachusetts, out-of-network utilization rates have skyrocketed, and the disparity between utilization rates for out-of-network M/S benefits and behavioral-health benefits is higher than the national average.
- From 2013 to 2017, out-of-network utilization for MH/SUD inpatient facilities increased from 2.15 times to 10.49 times that of M/S inpatient facilities. Reimbursement rates of primary-care physicians increased in Massachusetts from 51.0% higher than behavioral health in 2013 to 59.6% higher in 2017. Analogous rates have been observed in New York. Id. at 65 (showing the behavioral out-of-network inpatient utilization rate rising from 5.84 to 10.38 times that of M/S, and the primary-care reimbursement gap rising from 8.1% to 17.7%).

Note that disparities in other states may be far greater given how few have strong parity laws like New York or Massachusetts. See a report by the Kennedy-Satcher Center for Mental Health Equity, which gave 43 states a D or an F letter grade in 2018 based on the strength of their parity legislation. See Megan Douglas et al., Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report, KENNEDY F. 4 (2018), https://wellbeingtrust.org/wp-content/uploads/2019/06/evaluating-state-mental-health-report-wbt-for-web.pdf
Other studies that make similar assertions to BH disparities and low reimbursement rates -

- A recent Government Accountability Office (GAO) report revealed that mental health organizations cited inadequate reimbursement rates for services as one of the main reasons individuals cannot access mental health care, even when they have insurance. In

other words, there is not much of an incentive for providers to take insurance if they aren't guaranteed adequate payment.

- The U.S. Senate Committee on Finance in 2022 proposed a Medicaid demonstration project to address reimbursement rates, recognizing that low Medicaid reimbursement rates are worsening provider shortages.
    - Recent reports from Virginia and New Mexico recommend increasing reimbursement rates and ensuring that increased rates are passed to providers by the managed care entities, which should be included in any legislative fix.
- Nicole M. Benson & Zirui Song, Prices and Cost Sharing for Psychotherapy in Network Versus out of Network in the United States, 39 HEALTH AFFS. 1210, 1215 (2020) ("[D]eclining in-network prices over time . . . may discourage [mental health] providers from participating in insurance networks; for example, psychologists have reported low reimbursement rates as a primary deterrent to participating in Medicare.").
- In Feb. 2019, the Congressional Budget Office also saw unfair reimbursement rates in insurance plans, finding that commercial and Medicare Advantage plans paid on average 13-14% less than Medicare fee-for-service rates for mental health care and 12% more than the fee-for-service rates for other specialties.

Soule, R (2023) Summary of Behavioral Health Reimbursement Disparities, Unpublished Manuscript from the American Psychological Association