AMERICAN
PSYCHIATRIC
ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

Board of Trustees
2019-2020
Bruce J. Schwartz, M.D.
President
Jeffrey Geller, M.D., M.P.H.
President-Elect
Sandra DeJong, M.D., M.Sc.
Secretary
Gregory W. Dalack, M.D.
Treasurer

Altha J. Stewart, M.D.
Anita S. Everett, M.D.
Maria A. Oquendo, M.D., Ph.D.
Past Presidents

Eric M. Plakun, M.D.
Vivian B. Pender, M.D.
Kenneth Certa, M.D.
Cheryl D. Wills, M.D.
Jenny L. Boyer, M.D., Ph.D., J.D.
Melinda L. Young, M.D.
Annette M. Matthews, M.D.
Ayana Jordan, M.D., Ph.D.
Rahn Kennedy Bailey, M.D.
Richard F. Summers, M.D.
Rana Elmaghraby, M.D.
Michael Mensah, M.D., M.P.H.
Trustees

Assembly
2019-2020
Paul J. O'Leary, M.D.
Speaker
Joseph C. Napoli, M.D.
Speaker-Elect
Mary Jo Fitz-Gerald, M.D., M.B.A.
Recorder

Administration
Saul Levin, M.D., M.P.A.
CEO and Medical Director

June 5, 2019

The Honorable Lamar Alexander, Chair
Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Patty Murray, Ranking Member
Senate Committee on Health, Education, Labor and Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of the American Psychiatric Association (APA), the national medical specialty association representing over 38,500 psychiatric physicians, I want to again express my appreciation for your efforts to engage with stakeholders on public policy aimed at lowering the national cost of health care. As we expressed to you in February, we share your concern about the impact that the rising costs of health care have on physicians and our patients' ability to access quality evidence-based mental health and substance use disorder services. In response to your discussion draft of legislation released on May 23, we offer the following comments:

Achieving Mental Health and Substance Use Disorder Parity Compliance

The need for expanded treatment of mental health and substance use disorders cannot be understated. The National Institute of Mental Health (NIMH) estimates that 46.6 million Americans experienced a mental illness in 2017, of which 11.2 million were living with a serious mental illness. In that same year, an estimated 10.6 million adults had thoughts of suicide and an estimated 47,000 completed suicide. Annual deaths from opioid overdoses reached 70,000. Serious mental illness is costly in its human toll and to our health care system—more than $100 billion per year, according to NIMH.

Despite the intent of the Mental Health Parity and Addiction Equity Act ("federal parity law") to bring coverage for mental health and substance use disorders in line with coverage for other medical conditions, many insurers remain out of compliance with the federal parity law. This is particularly true in more complex matters relating to insurers' managed care practices such as utilization review. Since the federal parity law's passage more than ten years ago, inadequate oversight by regulatory authorities and a lack of transparency by insurers has enabled insurers to design these

requirements in a manner that disfavors the utilization or provision of mental health or substance use disorder services.

While a denial or delay of mental health or substance use disorder treatment harms individual patients, it also imposes higher downstream costs on the health care and social service systems. If these mental illnesses go untreated, or are inappropriately treated, a patient's risk of hospitalization, persistent or significant disability, or death is heightened both for patients with acute symptoms and for those receiving ongoing "maintenance" treatment. Mental illness can also exacerbate the cost of treating other comorbid diseases. For example, depression in the context of diabetes is also associated with poor self-care/non-adherence with respect to diabetes treatment, poor glycemic control, and increased health care use and expenditures regardless of gender, race, ethnicity, or health insurance status.[1]

APA strongly supports legislation being introduced by Senators Murphy and Cassidy that would provide some much-needed transparency as to how insurers apply their managed care practices to mental health and substance use disorder services. Specifically, the bill would require group health plans to perform comparative analyses of non-quantitative treatment limitations—including prior authorization requirements and step therapy protocols—for mental health and substance use services and submit those analyses to the Department of Labor upon receipt of a complaint against their coverage of these services.

The legislation would also require the Secretary to request, at random, that 50 plans annually submit their comparative analyses to the Secretary. It empowers the Secretary to provide out-of-compliance plans with corrective action needed to reach compliance. The legislation does not create or change the regulatory construct of the existing federal parity law, but instead fosters a system of transparency to ensure health plans are complying with their existing legal obligations.

Given the commendable goal of your bill to lower health care costs, the addition of parity compliance and transparency requirements will help achieve savings from the downstream costs of unnecessarily denied or delayed mental health or substance use disorder treatment. Accordingly, APA recommends that the Committee work with Senator Cassidy and Senator Murphy to include parity language in this legislation.

Protecting the Privacy of Electronic Health Information

The APA supports Section 503 of the bill, which calls for a GAO study on the security risks of electronic transmission of patients' health information to and from entities not covered by HIPAA. As you may know, the Office of the National Coordinator for Health Information Technology (ONC) released a Notice of Proposed Rule Making (NPRM) titled, "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program." The Rule expands the definition of patient health information beyond HIPAA's current conception of "electronic protected health information" to an entirely new construct of "electronic health information," or EHI.

---

[1] Egede LE, Zheng D, Simpson K. Comorbid depression is associated with increased health care use and expenditures in individuals with diabetes. Diabetes Care. 2002;25(3):464–470. [PubMed] [Google Scholar]

The rule's definition of EHI is expansive and includes data potentially found within mobile apps such as electronic health records. The rule also proposes that this data is shared using open "application programming interfaces" (APIs), with little regard to regulation determining the ultimate security and privacy risks to patient health information that is sent, received, and stored via this process. These concerns were echoed by your Committee during recent testimony featuring Dr. Donald Rucker from ONC.

The GAO study described in your bill would help to address these concerns by delineating the respective roles of federal agencies and the private sector in protecting the privacy and security of EHI, identifying how to ensure that APIs entering the market are private and secure, identifying private sector business practices that would ensure the transparency as to how vendors use and protect EHI in the possession of entities not covered by HIPAA, and providing guidance for both the public and private sectors in improving the privacy and security of data not covered by HIPAA.

The social stigma that often accompanies a mental health or substance use disorder diagnosis heightens the need for strong protections against the inappropriate use or disclosure of EHI. The APA supports these provisions within your bill and looks forward to working with members of Congress to ensure that patients' private information concerning their history of mental health or substance use disorder treatment remains protected from unwarranted disclosure by third party business developers as APIs continue to enter the market.

Fostering Transparency in Health Care Costs

During the many hearings on this topic in both chambers of Congress, several members expressed concern that rising drug prices are causing many critical, life-saving medications to become unaffordable to patients. APA shares this concern. Although many medications used to treat mental health disorders have a higher overall rate of generic utilization, generic drugs are by no means immune to major price increases. A recent study[2] shows that the portion of generic drugs that at least doubled in price in successive years represents a small but growing share of the market: from 1% of all generic drugs in 2007 to more than 4.39% in 2013.

As you know, prescription drug price increases also contribute to higher premiums charged to both employers and employees, greater outlays from public programs like Medicare and Medicaid, and greater out-of-pocket costs for patients. In many cases, payers are responding to the higher costs of covering prescription drugs by removing certain drugs from their approved formularies or placing them on higher cost-sharing tiers, or by requiring that patients and physicians comply with additional utilization management protocols such as prior authorization or "step therapy" requirements. Patients with lower or fixed incomes often respond to increasing costs of drugs by reducing the strength of their medications or by skipping doses entirely.

---

[2] USC Schaeffer Center for Health Policy & Economics, "Do Price Spikes on Some Generic Drugs Indicate Problems in the Market?" (Oct. 1, 2018), available at: https://news.usc.edu/149667/do-price-spikes-on-some-generic-drugs-indicate-problems-in-the-market/.

In February, APA asked the Committee to consider proposals that would "enhance transparency as to how manufacturers set the list prices of drugs." A lack of transparency from insurers has enabled health plans to impose coverage requirements that disproportionately impact mental health and substance use disorders. **Accordingly, APA supports Section 302 of the Committee's bill, which bans certain provisions in contracts between insurers and providers that effectively handcuff the ability of providers to refer patients to providers and facilities that demonstrate higher quality and lower prices**.

APA also supports Section 301 of the Committee's bill, which bans so-called "gag clauses" in contracts between providers and health plans that prevent patients or providers from seeing cost and quality data on providers. Last year, APA supported a similar proposal that bans these clauses in contracts with drug manufacturers and PBMs forbidding disclosure of the difference between the amount of the drug's copay under a patient's insurance plan and the amount they would pay for the drug without using their insurance. At the time, we cited a study[3] showing that almost a quarter (23%) of all prescriptions filled in 2013—including drugs commonly used to treat insomnia, depression, and some side effects of psychiatric medications—involved a patient copayment that exceeded the average price of the drug by more than $2.00. Without enhanced transparency in a broader health care space, it is impossible for providers to know whether the services they recommend to their patients are the highest quality and most cost-effective solution for their patients.

Fostering Innovative Models of Integrated MH/SUD Care

As APA expressed to the Committee in February, "the effective integration of medical and behavioral health care services is estimated to save approximately $37-$69 billion annually." We recommended incentives that would facilitate greater adoption of the Collaborative Care Model (CoCM), which is led by a primary care provider to bring together a team of care managers, and a consulting psychiatrist, to develop a treatment plan for patients, focusing resources on patients who are not getting better and facilitating treatment adjustments. This improves access to mental health services by providing support to primary care providers treating patients with mental health and substance use conditions. Section 404 of your draft bill authorizes grants to "evaluate, develop, and expand the use of technology-enabled collaborative and capacity building models to increase access to specialty health care services in medically underserved areas and for medically underserved populations**."** **While we support the provision and education though "technology-enabled collaborative learning" such as the ECHO model, we encourage the Committee to ensure that evidence-based treatment models such as the Collaborative Care Model are also eligible**. While both CoCM and the ECHO model have a strong evidence base for expanding access to health care services through technology-enabled solutions, CoCM focuses specifically on serving patients with mental health needs and on achieving specific patient outcomes.

---

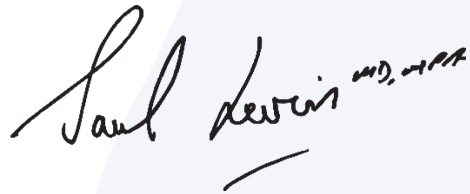
[3]USC Schaeffer Center for Health Policy & Economics, Overpaying for Prescription Drugs: The Copay Clawback Phenomenon (March 2018), available at: https://healthpolicy.usc.edu/wpcontent/uploads/2018/03/2018.03_Overpaying20for20Prescription20Drugs_White20Paper_v.1- 2.pdf.

Improving Maternal and Postpartum Depression

APA appreciates the inclusion of Section 406, which establishes a new grant program "for the purpose of…eliminating preventable maternal mortality and severe maternal morbidity by identifying, developing, and disseminating best practices to improve maternal health outcomes." An estimated 14%-23% of pregnant women will experience a depressive disorder while pregnant[4], and suicide during or shortly after pregnancy remains a leading cause[5] of preventable perinatal death. **APA hopes that the grant program envisioned by your bill will enable providers and states to improve and expand mental health treatment for expecting and new mothers.**

Thank you again for the Committee's efforts to identify and execute bipartisan strategies to lower the costs of healthcare in our system. We welcome the opportunity to participate in your efforts to produce strong, impactful legislation. If you have any questions, please contact Mike Troubh at mtroubh@psych.org or (202) 559-3571.

Sincerely,



Saul Levin, MD, MPA, FRCP-E
CEO and Medical Director

---

[4] Kimberly Yonkers, MD, et. al., "The Management of Depression During Pregnancy: A Report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists", J. Obstet. & Gynecology (Sept. 2009), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3103063/.

[5] See, e.g., Cristie Palladino, MD, MSc et. al., "Homicide and Suicide During the Perinatal Period: Findings from the National Violent Death Reporting System", J. Obstet. & Gynecology (Nov. 2011), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3428236/.