



**Equitable Access to Mental Health
and Substance Use Care:
An Urgent Need**

Patient-experience survey shows stark access barriers
for mental health versus physical health

BOWMAN FAMILY
FOUNDATION

NORC, an independent, non-partisan research institute at the University of Chicago, conducted a survey of patients in order to understand their experiences in accessing mental health and/or substance use care. NORC obtained IRB approval for the survey and operated under a Certificate of Confidentiality from the National Institutes of Health. All numerical data in this report related to survey responses was prepared by NORC or derived directly from numerical data prepared by NORC.

The opinions and recommendations in this report are those of the authors.

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Supporters

The Urgent Recommendations in This Report Are Put Forth by:

National Employer Coalitions

American Health Policy Institute
HR Policy Association
National Alliance of Healthcare Purchaser
Coalitions

Regional Employer Coalitions

Dallas-Fort Worth Business Group on Health
Florida Alliance for Healthcare Value
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Mental Health/Substance Use Organizations and Philanthropies

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Association for Behavioral and Cognitive
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BrainFutures
Eating Disorders Coalition for Research, Policy,
& Action
Faces & Voices of Recovery
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Steinberg Institute
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Treatment Advocacy Center
Young People in Recovery

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Executive Summary

Due to the deepening mental health and substance use crisis in the U.S., there's an urgent need for equitable access to care that is timely, clinically effective, and adequately reimbursed by insurers. This need encompasses psychiatrists, psychologists, social workers, other counselors, and treatment facilities as well as mental health and substance use care delivered by primary care providers.

Multiple studies, including analyses of insurance claims and surveys of employers and providers, have demonstrated that in-network health insurance coverage for treatment of mental health and substance use conditions remains inadequate and not “on par” with access to in-network health insurance coverage for physical health treatment.

This patient-experience survey conducted by [NORC](#) (Survey) explored key topics such as: 1) how often mental health or substance use care is needed but not received; 2) how difficult it is to find in-network providers accepting new patients; 3) how often and why patients use out-of-network providers for mental health or substance use care versus physical health care; 4) how often patients feel that mental health or substance use care from PCPs and other physical health providers is insufficient; 5) how often services are denied; and more.

The Survey used convenience sampling across 26 behavioral health consumer organizations, behavioral health provider groups, and employer coalitions that distributed the NORC Survey link to their members, visitors, and followers via email, website, and/or social media at various periods between December 2021 and April 2022. In total, 2,794 responses to the Survey were received from patients who needed care between January 2019 through April 2022 and had a wide range of insurance types (commercial, Medicaid, Medicare, etc.). 48% of responses were from patients completing the Survey on their own, and 52% of responses were by family members, friends, providers, or others on behalf of patients (including all patients under 18).

Questions in the Survey were developed with input from survey experts, purchasers such as self-insured employer coalitions, mental health and substance use non-profit organizations, and a leading commercial insurer.

Key Findings:

- 57%¹ of patients sought mental health or substance use care but did not receive any care in at least one case, compared to 32% of patients seeking physical health care.
 - For children and teens under 18 (defined here as “adolescents”), the “care not received” figure was 69% for mental health or substance use compared to 17% for physical health. This indicates that adolescents had worse access than adults to mental health and substance use care, but better access than adults to physical health care.
- 40% of patients using health insurance who received outpatient care from an in-network mental health or substance use provider, compared to 14% for physical health providers, had to contact 4 or more in-network providers before they were able to obtain an appointment with a new in-network provider.
- 39% of patients in employer-sponsored health plans used at least one out-of-network mental health or substance use provider for outpatient care, compared to 15% for physical health providers. As shown in Figure 4e, the mental health and substance use percentages for six major insurers ranged from 25% to 53%.
 - 80% of patients in employer-sponsored health plans who received outpatient care from at least one out-of-network mental health or substance use provider said they went to out-of-network providers “all of the time”, compared to just 6% of patients who said the same for physical health care.

This data is important because patients who use out-of-network providers face the financial burden of higher co-pays and deductibles.

- 87% of patients of all ages who received mental health or substance use care from physical health providers felt that they needed additional help from a mental health

¹ All Survey percentages throughout this report are rounded. Survey results represent all insurance types combined except where otherwise noted.

or substance use specialist. Figures 5b and 5c provide comparable data by type of insurance and by insurer.

- 98% of adolescent patients who received mental health or substance use care from physical health providers felt that they needed additional help from a mental health or substance use specialist.

Other Studies Examining Network Access

Mental health and substance use access barriers have existed for decades. At least five other studies that were conducted in 2022 and 2023 demonstrate the continuation of major gaps in access. All of the research methods—whether surveys of various stakeholders or claims data—reveal results consistent with each other and the Survey conducted by NORC.

For instance:

- The recently released [Voice of the Purchaser survey of 220 employers](#) conducted in 2023 by the [National Alliance of Healthcare Purchasers Coalition](#) and the [HR Policy Association](#) (National Alliance of Healthcare Purchaser Coalitions, 2023) found that only 31% of employers were satisfied with their members’ access to in-network behavioral health providers.
- The 2022 [survey of 2,188 employers](#) conducted by the [Kaiser Family Foundation](#) (Claxton et al., 2022) found that 82% of employers said that their largest health plan had enough primary care providers to provide timely access to services versus only 44% who said there were enough behavioral health providers to provide timely access to services.
- The [surveys of patients](#) by [Susan H. Busch and Kelly A. Kyanko](#) (Busch & Kyanko, 2023) found:
 - “...among patients receiving both mental health and medical/surgical care, many more patients used an out-of-network mental health provider (33% versus 19%)...”
 - “Differences in out-of-network health care use likely underestimate the extent of mental health network inadequacy.”
 - “...the high rates of [out-of-network] mental health compared to [out-of-network] medical/surgical care are not primarily due to differences

in the reasons individuals use [out-of-network] mental health providers.”

- The [Senate Committee on Finance, Majority Staff Secret Shopper study](#) of 2023 (Senate Committee on Finance Majority, 2023) found that, when calling mental healthcare providers listed as being in-network with Medicare Advantage plans, more than 80% were either unreachable, not accepting new patients, or not in-network; 33% had inaccurate or non-working numbers or resulted in unreturned calls; and only 18% of providers called resulted in an appointment.
- In February 2023, the [Healthy Minds Policy Initiative investigation](#) (Healthy Minds Policy Initiative, 2023) concluded that “the majority of behavioral health providers listed by insurance networks appear unavailable or unreachable—many with disconnected phone lines”, and insurance networks in Oklahoma omit between 63-71% of psychiatrists and 66-67% of substance use treatment providers in the state.
- The 2020 [Milliman high-cost report](#) (Davenport, et al., 2020), [analyzing insurance claims](#) of 21 million lives, found that 50% of all behavioral health patients (or 2.8 million individuals) received minimal or no behavioral care in 2017.
- The 2019 [Milliman insurance claims disparity report](#) (Melek, et al., 2019) covering 39 million lives found that a behavioral healthcare office visit for a child was 10 times more likely to be out-of-network than a primary care visit—twice the disparity seen for adults. In 2017, using Medicare reimbursement as a benchmark, commercial primary care reimbursement was shown to be 23.8% higher than behavioral reimbursement.

Further details regarding these studies and more are set forth in Appendix 1.

This overwhelming evidence of significant lack of access to specialty mental health and substance use care, which has existed for decades and is continuing in 2023, coupled with escalating rates of suicide and overdoses (Warren, 2022), makes clear that lack of access to effective mental health and substance use care is a staggering public health challenge.

Recommendations

Given the scale of the current mental health and substance use crisis, all employers, states, insurers, and where relevant, health systems and clinicians at both the national and local levels should implement these urgent recommended solutions:

- **Expand mental health and substance use networks:** Add appropriately credentialed mental health and substance use providers of all levels of care to commercial, Medicaid and Medicare networks, through proactive network recruiting efforts driven by dedicated network expansion teams; fast tracking credentialing and other network admission requirements for all mental health and substance use providers; increasing reimbursement rates wherever shortages of in-network mental health and substance use providers exist; and decreasing unpaid hours of work by reducing administrative burdens such as pre-authorizations and retrospective claims audits. Using independent third parties, insurers should implement auditing of (i) the accuracy of their behavioral network directories (e.g., using secret shopper surveys) and (ii) compliance with their network adequacy standards.
- **Integrate mental health services into primary care using clinically effective methods:** There are several evidence-based methods of integrating mental health and substance use care into primary care, such as the [Collaborative Care Model \(CoCM\)](#) and Primary Care Behavioral Health Model (PCBH). Both models improve mental health outcomes for patients (relative to treatment as usual in primary care) by involving a behavioral health specialist (such as a psychologist, social worker, or psychiatrist) who supports primary care providers. In CoCM, the primary care provider (PCP) is supported by a behavioral health care manager, who becomes part of the primary care team, and a virtual psychiatric consultant who advises both the treating PCP and the behavioral health care manager on effective use of psychotropic medications and other care topics. The clinical effectiveness of this approach, and its ability to reduce the need for separately delivered specialty behavioral care, is supported by a substantial evidence base that includes more than 80 randomized trials and [endorsements](#) by 18 leading medical, business and non-profit organizations.

To expand availability of integrated care models to all Americans: 1) insurers should provide training and financial support to enable primary care to implement evidence-based integrated care; 2) all states should turn on Medicaid payment codes for CoCM and general behavioral health integrated care (BHI care) including G0323; 3) state Medicaid agencies should pay at least Medicare rates for CoCM and BHI codes; 4) commercial insurers should pay well above Medicare for CoCM and BHI codes; 5) commercial insurers (and ultimately Medicare and Medicaid) should eliminate or reduce patient out-of-pocket expenses for CoCM, PCBH, and other methods of integration.

It is important to note that use of both CoCM and BHI codes requires providers to screen and systematically assess patients using validated clinical rating scales.

- **Cover and pay for video and audio-only mental health services, at parity with in-person care:** Evidence exists that, for many of the most common behavioral health conditions, tele-behavioral care is effective (Lazur, et al. 2020; Varker et al., 2019). Accordingly, insurers should provide coverage, with equivalent reimbursement, for in-person and tele-behavioral visits (video and phone calls) as was sometimes done during the worst of COVID-19. Even though tele-behavioral services may not replace all types of mental health and substance use care (e.g. inpatient programs, some intensive outpatient programs, and clinically complex cases), for many—especially those most vulnerable—tele-behavioral may be the only realistic option.

The results of the Survey indicate higher than average preferences among Medicaid and Black/African American patients for audio-only tele-behavioral care. Future research will determine if there are significant differences (in terms of both clinical efficacy and patient preferences) between audio-only, video, and in-person sessions for other sub-populations in order to ensure that evidence guides regulations and insurer practices regarding tele-behavioral services.

- **Fully comply with and enforce federal and state parity laws:** The volume of evidence showing disparities between access to mental health and substance use care versus physical health care from this Survey and prior studies underscores the importance of full compliance with and enforcement of federal and state parity laws.

We urge the Departments of Labor, Health and Human Services and the Treasury to: 1) issue additional guidance on detailed templates for Mental Health Parity and Addiction Equity Act (MHPAEA) compliance data reporting as guidance to employer group plans, third party administrators and insurance issuers, indicating what data they should be prepared to submit upon request, and 2) release the past due annual MHPAEA Nonquantitative Treatment Limitation (NQTL) Report to Congress.

While a number of health plans are beginning to implement one or more of the three solutions set forth above as a way in which to address access to care

disparities, the fact that significant disparities still exist in 2022 and 2023 points to the need for much greater efforts.

Similar to the collective action taken to address the COVID-19 pandemic, the mental health and substance use crisis requires immediate and decisive actions by all stakeholders: private and public insurers, employers, providers, consumer organizations, and federal and state governments.

Background

The U.S. is facing an unprecedented mental health crisis. According to the National Institute for Health Care Management (NIHCM) Foundation, in the 10-year period from 2008 to 2018, rates of any mental illness increased 8% and rates of serious mental illness increased 24% (NIHCM Foundation, 2020). More recent data from the National Alliance on Mental Illness (NAMI) shows that 22.8% of U.S. adults (57.8 million people) experienced mental illness and 7.6% of U.S. adults (19.4 million people) experienced a co-occurring substance use disorder and mental illness in 2021 (National Alliance on Mental Illness, 2023).

Yet, according to NIHCM Foundation, almost 57% of adults with mental health illness and close to 36% of adults with serious mental health illness received no treatment (NIHCM Foundation, 2020). Of those who access office-based care, more than 50% receive it from primary care providers (Fortney et al., 2015), and most psychiatric medications are prescribed by primary care providers (Mark et al., 2009). Numerous studies have documented the limitations of treatment being provided by primary care without additional behavioral resources. For example:

“Only 13% of people diagnosed with a mental health condition receive minimally adequate treatment in a

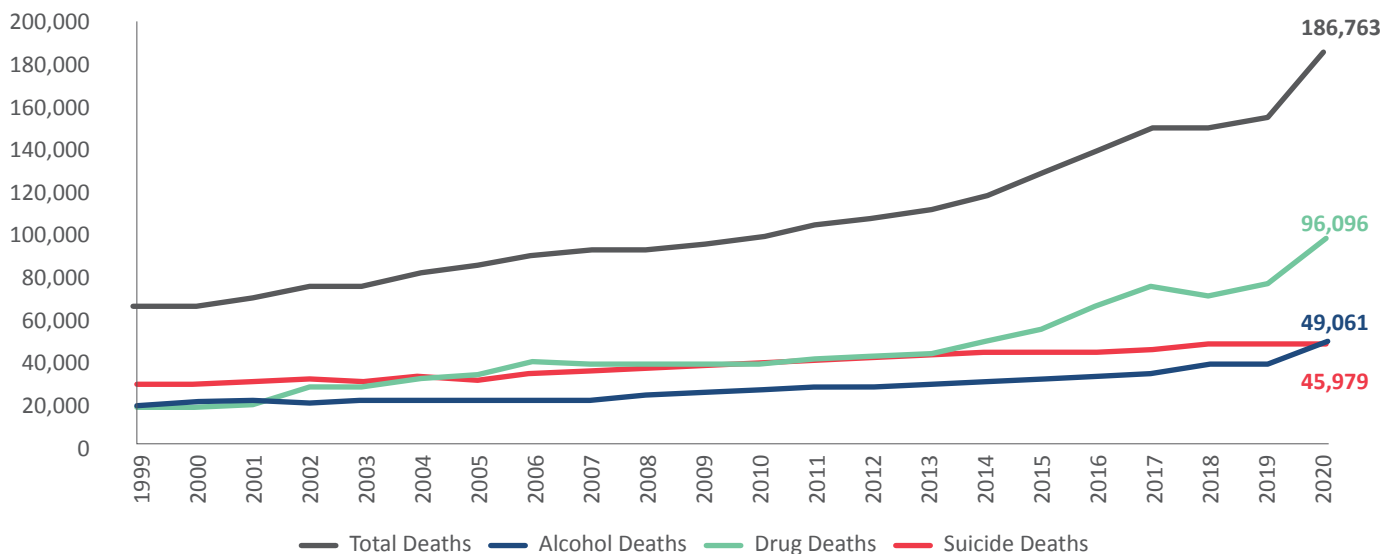
general medical setting; for substance use disorders, that number drops to a dismal 5%” (Fortney et al., 2015) (See other references [here](#))

The numbers are even more dire for adolescents and young adults. An article in JAMA reported that 57% of teen girls experienced persistent sadness or hopelessness in 2021 (Harris, 2023). In addition, 30% of teen girls seriously considered suicide. NIHCM Foundation reported that rates of mental illness among 18- to 25-year-olds increased from approximately 19% to 26% between 2008 and 2018, and noted that 75% of all mental illnesses develop by the age of 24 (NIHCM Foundation, 2021). Among teens and young adults reporting a major depressive episode within the previous year, less than half received treatment. Additionally, suicide rates increased, making suicide the 2nd leading cause of death among 10- to 24-year-olds in 2017.

Overall deaths attributed to alcohol, drugs and suicide increased dramatically between 1999 and 2020, with the rate of increase growing steeply from 2015-2020 (Fig. 1).

This data points to a healthcare delivery system that is failing patients with mental health and substance use conditions. Rates of illness and deaths related to behavioral

Figure 1: Annual Deaths from Alcohol, Drugs, and Suicide in the United States, 1999–2020



Source: TFAH and WBT analysis of National Center for Health Statistics data (Warren, 2022)

health conditions are steadily increasing while far too many people are receiving inadequate care or no care.

The Cost of Inadequate Access to Mental Health and Substance Use Care

Lack of access to mental health and substance use care is a key driver of increases in physical health (and therefore, overall) healthcare costs. According to the National Institutes of Mental Health (NIMH), people with depression have an increased risk of cardiovascular disease, diabetes, stroke, pain, and Alzheimer's disease, and may be at a higher risk for osteoporosis (NIMH, 2021). The NIMH also suggests that people with mental health disorders may have more difficulty accessing physical health services.

The connection between mental health and substance use conditions and high physical health costs was underscored in Figure 9 of the [Milliman High Cost report](#) (Davenport, et al., 2020), excerpts of which are set forth in Appendix 2.

The Milliman analysis, which included all insurance claims of 21 million patients, demonstrated that patients with mental health diagnoses have 3.4 times higher annual total healthcare costs compared to patients with no behavioral health diagnosis. Patients with substance use disorder diagnoses have 5.6 times higher annual total healthcare costs compared to patients with no behavioral health diagnosis.

In both cases, Medical/Surgical (i.e., physical health) costs are the vast majority of total costs.

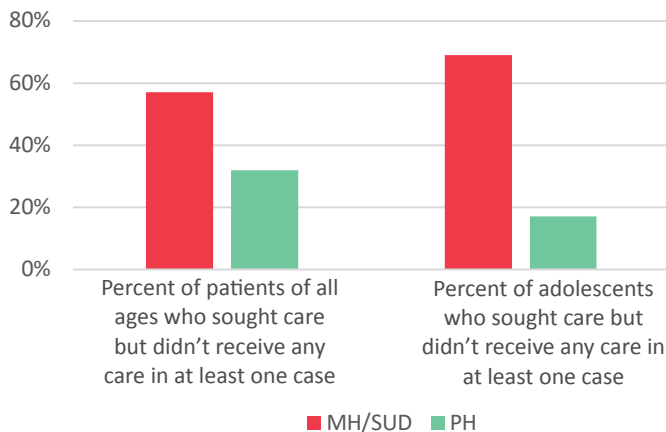
Highlights of the Survey Conducted by NORC

The Survey was designed to elicit information regarding the experiences of patients seeking access to in-network health-care services. As noted earlier, the methodology included convenience sampling based on people who responded to notices about the Survey from a range of organizations, which are listed in Appendix 3. Appendix 4 includes additional information regarding the Survey methodology, demographics, and types of insurances analyzed.

Highlights of a few key Survey findings are below. Further information regarding these and many other findings are shown via graphs in Addendum A and in a master table in Addendum B. The additional data included in these addenda address topics such as: out-of-network use for individually purchased private plans; how often and why patients with insurance cannot, or elect not to, use it; how patients view tele-behavioral services compared to in-person services; how patients view behavioral health digital tools such as apps; and the impact of COVID-19.

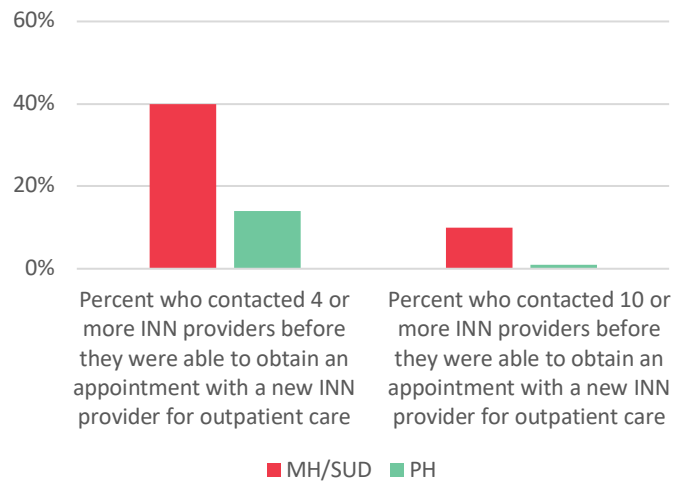
Note for Figure 2: This data show that a substantial proportion of people seeking mental health and substance use care are not receiving it.

Figure 2: Sought Care But Didn't Receive Any Care At Least Once



Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

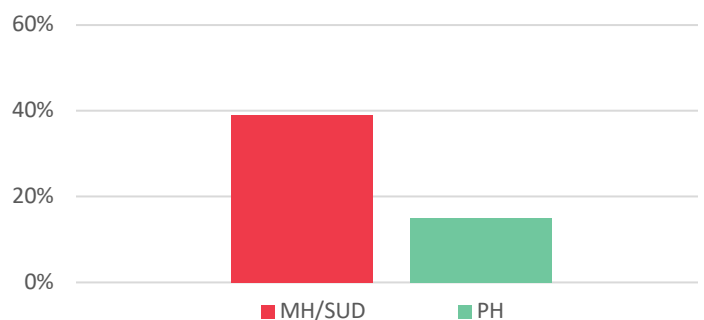
Figure 3a: Number of In-Network Providers Contacted Before Appointment Obtained



Note: INN=In-network; MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

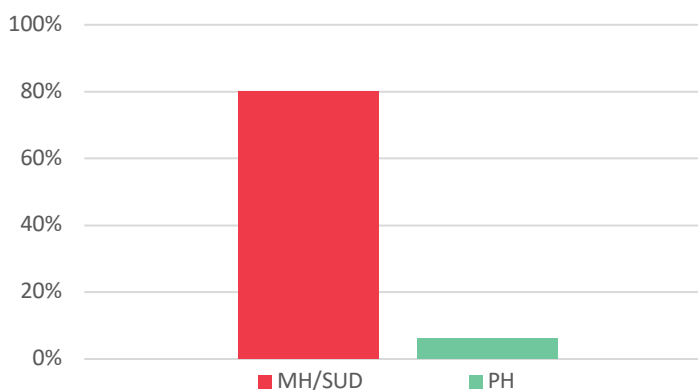
Figures 4a, 4b, and 4e. Use of Out-of-Network Providers

Figure 4a: Employer-Sponsored Plans: Percentage of Patients Who Received Care in an Outpatient Setting From At Least One Out-of-Network Provider



Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use.
Source: Survey conducted by NORC, 2022

Figure 4b: Employer-Sponsored Plans: Among Patients Who Received Care in an Outpatient Setting From At Least One Out-of-Network Provider, Percentage Who Indicated that They Went to an Out-of-Network Provider “All Of The Time”



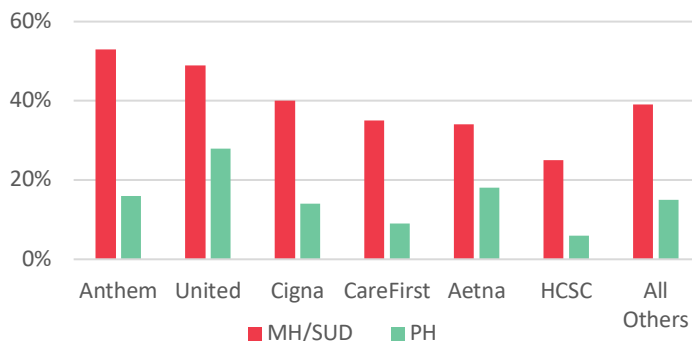
Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use.

Source: Survey conducted by NORC, 2022

Notes for Figures 4a & 4b: Use of out-of-network provider services was much higher for mental health or substance use care compared to physical health care. For example, for patients with employer-sponsored insurance plans (which frequently have out-of-network benefits), 39% used at least one out-of-network mental health or substance use provider for outpatient care compared to 15% for physical health providers (Fig. 4a). 80% of patients in employer-sponsored health plans who received outpatient care from at least one out-of-network mental health or substance use provider said they went to out-of-network providers “all of the time”, compared to just 6% of patients who said the same for physical health care (Fig. 4b). This disparity in accessing in-network care places a substantially greater financial burden on mental health/substance use patients as compared to physical health patients.

Figure 4e: Received Care In An Outpatient Setting From At Least One Out-of-Network Provider, By Insurance Company

(Employer-Sponsored and Individually Purchased Plans Combined)



Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use.

“Anthem” includes Blue Cross and Blue Shield and affiliated blue plans in 14 states. “CareFirst” is a BlueCross BlueShield plan providing service in 3 areas.

“United” includes Optum United Behavioral Health (“UBH”) and United Healthcare (“UHC”) combined.

“HCSC” includes Blue Cross and Blue Shield plans in 5 states.

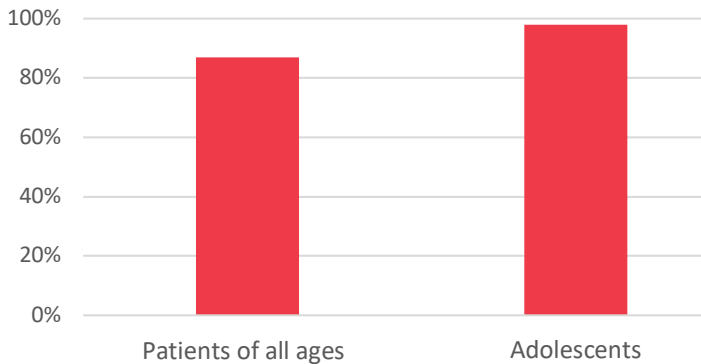
Source: Survey conducted by NORC, 2022

Note for Figure 4e: Patients in both employer-sponsored plans and individually-purchased private plans were asked to identify their insurance carriers. Across all major carriers, patients received substantially more mental health or substance use services out-of-network than physical health services, but with considerable variation among insurance carriers.

Figures 5a, 5b, and 5c. Mental Health and Substance Use Care by Physical Health Providers Is Viewed as Insufficient

The “Background” section of this report referenced data showing that more than half of patients who receive office-based mental health and substance use treatment receive it from primary care providers, and most psychiatric medication is prescribed by primary care providers.

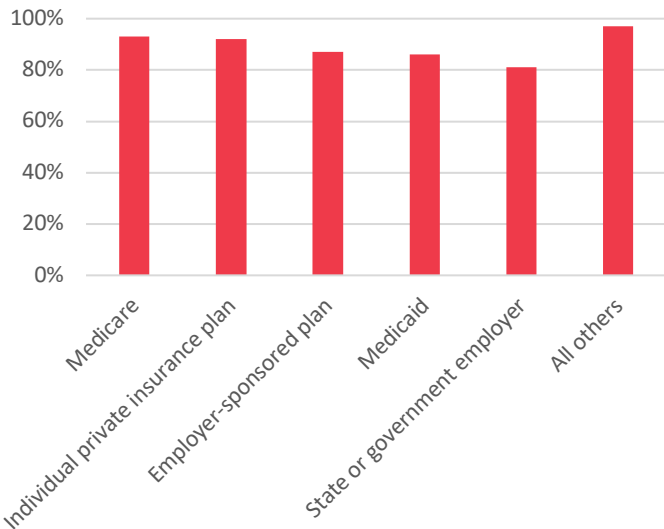
Figure 5a: Needed Additional Help From a Mental Health or Substance Use Specialist After Receiving Mental Health or Substance Use Care from Physical Health Providers



Percentage of patients who felt they *needed additional help* from a mental health or substance use specialist after receiving mental health or substance use care from physical health providers

Source: Survey conducted by NORC, 2022

Figure 5b: Needed Additional Help From a Mental Health or Substance Use Specialist After Receiving Mental Health or Substance Use Care from Physical Health Providers – By Insurance Type



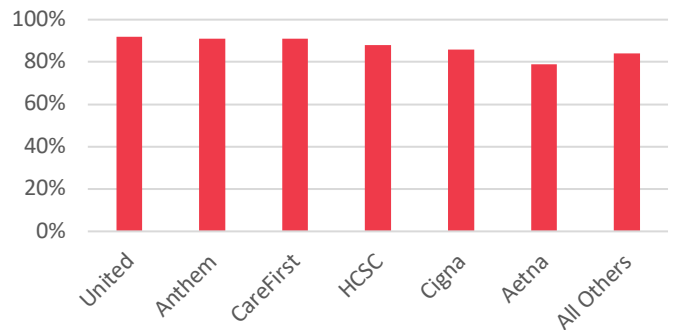
Source: Survey conducted by NORC, 2022

However, “treatment as usual” is insufficient to address patients’ needs, which is why implementation of integrated care models is so important.

To gain perspective about the level of satisfaction with “treatment as usual” services, the Survey asked patients how satisfied they were with mental health or substance use treatment that they received from physical health providers: 87% of patients of all ages who received mental health or substance use care from physical health providers felt that they needed additional help from a mental health or substance use specialist. This figure was 98% for adolescent patients (Fig. 5a). Figures 5b and 5c show the results by insurance type and insurance carrier (which represents employer-sponsored plans and individual private insurance plans combined).

Figure 5c: Needed Additional Help From a Mental Health or Substance Use Specialist After Receiving Mental Health or Substance Use Care from Physical Health Providers – By Insurance Carrier

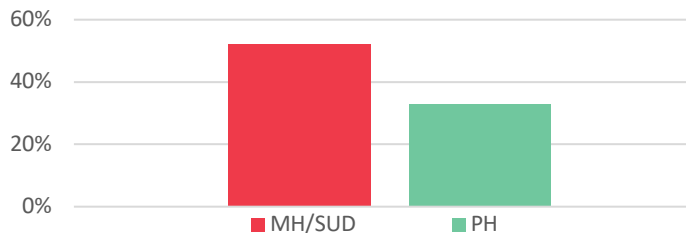
(Employer-Sponsored and Individually Purchased Plans Combined)



Source: Survey conducted by NORC, 2022

Figure 6a. Denial of Claims

Figure 6a: Percentage of Patients Who Reported that Their Health Insurance Denied Coverage Three or More Times



Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Conclusions and Recommendations

The findings from the Survey support those from numerous other studies—all pointing to a substantial inequity in access to care for individuals with mental health and substance use conditions when compared to those with physical health conditions. The evidence for this inequity has been reported for decades and is continuing into 2023—even as the need for mental health and substance use care has steadily increased.

These inequities have been demonstrated with respect to all types of payers. For example, several recent studies show gaps in mental health and substance use coverage in Medicare (Legal Action Center, 2021; Legal Action Center, 2022; Weber & Steinberg, 2021).

From this substantial body of evidence, several key observations have emerged.

- The need for mental health and substance use care, especially among adolescents and young adults, has been growing and is at a crisis level, while patients continue to face stark access barriers.
- Although PCPs provide office-based mental health and substance use care to more than half of patients receiving such care and prescribe most psychiatric medications, Survey results show that treatment as usual in primary care is insufficient. While we continue to address the need for greater access to mental health and substance use specialists, we also must optimize the use and effectiveness of primary care by providing more behavioral health resources to primary care as this is the natural treatment setting for many mental health and substance use patients.
- The growing mental health and substance use crisis and lack of access to in-person care has spurred newer service models that expand access. These include tele-behavioral health, which increases access to existing mental health and substance use specialists, and app-based solutions that do not require direct interactions with mental health and substance use specialists. As shown by the Survey data in Addenda A and B, there is an urgent need for an independent service to objectively evaluate the level of use and effectiveness of apps

in “real world” day-to-day use, in order to guide the choices made by providers and patients.

- Although the Mental Health Parity and Addiction Equity Act (MHPAEA) (Wellstone, et al., 2008) was enacted 15 years ago, continuing significant disparities between access to mental health and substance use care versus physical health care indicate gaps in compliance.

Recommendations

Given the scale of the current mental health and substance use crisis, all employers, states, insurers, and where relevant, health systems and clinicians at both the national and local levels should implement these urgent recommended solutions:

■ EXPAND MENTAL HEALTH AND SUBSTANCE USE NETWORKS:

Add appropriately credentialed mental health and substance use providers of all levels of care to commercial, Medicaid and Medicare networks, through:

- Proactive network recruiting efforts driven by dedicated network expansion teams
- Fast tracking credentialing and other network admission requirements for all mental health and substance use providers
- Increasing reimbursement rates wherever shortages of in-network mental health and substance use providers exist
- Decreasing unpaid hours of work by reducing administrative burdens such as pre-authorizations and retrospective claims audits

Using independent third parties, insurers should implement auditing of (i) the accuracy of their behavioral network directories (e.g., using secret shopper surveys) and (ii) compliance with their network adequacy standards.

The disincentive to join networks caused by low reimbursement and high administrative burden has been chronicled in many interviews with and surveys of various types of mental health and substance use providers—a few examples are set forth in [this letter](#) by the American Psychiatric Association.

■ INTEGRATE MENTAL HEALTH SERVICES INTO PRIMARY CARE USING CLINICALLY EFFECTIVE METHODS:

There are several evidence-based methods of integrating mental health and substance use care into primary care, such as the [Collaborative Care Model \(CoCM\)](#) and Primary Care Behavioral Health Model (PCBH). Both models improve mental health outcomes for patients (relative to treatment as usual in primary care) by involving a behavioral health specialist (such as a psychologist, social worker, or psychiatrist) who supports primary care providers. In CoCM, the primary care provider (PCP) is supported by a behavioral health care manager, who becomes part of the primary care team, and a virtual psychiatric consultant who advises both the treating PCP and the behavioral health care manager on effective use of psychotropic medications and other care topics. The clinical effectiveness of this approach, and its ability to reduce the need for separately delivered specialty behavioral care, is supported by a substantial evidence base that includes more than 80 randomized trials and [endorsements](#) by 18 leading medical, business, and non-profit organizations.

Multiple studies demonstrate that integrated care improves clinical outcomes, increases patient and provider satisfaction, reduces health inequities, and reduces costs (Jackson-Triche, 2020; Reist, 2022).

To expand availability of integrated care models to all Americans:

- Insurers should provide training and financial support to enable primary care to implement evidence-based integrated care
- All states should turn on Medicaid payment codes for CoCM and general behavioral health integrated care (BHI care) including G0323
- State Medicaid agencies should pay at least Medicare rates for CoCM and BHI codes
- Commercial insurers should pay well above Medicare for CoCM and BHI codes
- Commercial insurers (and ultimately Medicare and Medicaid) should eliminate or reduce patient out-of-pocket expenses for CoCM, PCBH, and other methods of integration

“The Collaborative Care Model is one of very few specific interventions in medicine that have been shown via multiple RCTs to reduce disparities by race/ethnicity and/or socioeconomic status in patients’ access to care, quality of care, and outcomes.”

Michael Schoenbaum, PhD
Senior Advisor for Mental Health Services
National Institute of Mental Health

It is important to note that use of both CoCM and BHI codes requires providers to screen and systematically assess patients using validated clinical rating scales.

■ COVER AND PAY FOR VIDEO AND AUDIO-ONLY MENTAL HEALTH SERVICES, AT PARITY WITH IN-PERSON CARE:

Evidence exists that, for many of the most common behavioral health conditions, tele-behavioral care is effective (Lazur, et al. 2020; Varker et al., 2019). Accordingly, insurers should provide coverage with equivalent reimbursement, for in-person and tele-behavioral visits (video and phone calls) as was sometimes done during the worst of COVID-19. Even though tele-behavioral services may not replace all types of mental health and substance use care (e.g., inpatient programs, some intensive outpatient programs, and clinically complex cases), for many—especially those most vulnerable—tele-behavioral may be the only realistic option.

The results of the Survey indicate higher than average preferences among Medicaid and Black/African American patients for audio-only tele-behavioral care. Future research will determine if there are significant differences (in terms of both clinical efficacy and patient preferences) between audio-only, video, and in-person sessions for other sub-populations in order to ensure that evidence guides regulations and insurer practices regarding tele-behavioral services.

■ FULLY COMPLY WITH AND ENFORCE FEDERAL AND STATE PARITY LAWS:

The volume of evidence showing disparities between access to mental health and substance use care versus physical health care from this Survey and prior studies underscores

the importance of full compliance with and enforcement of federal and state parity laws.

We urge the Departments of Labor, Health and Human Services and the Treasury to: 1) issue additional guidance on detailed templates for Mental Health Parity and Addiction Equity Act (MHPAEA) compliance data reporting as guidance to employer group plans, third party administrators and insurance issuers, indicating what data they should be prepared to submit upon request, and 2) release the past due annual MHPAEA Nonquantitative Treatment Limitation (NQTL) Report to Congress.

In addition, we urge CMS to provide greater oversight to state parity compliance reviews of Medicaid MCOs.

While a number of health plans are beginning to implement one or more of the three solutions set forth above as a way in which to address access to care disparities, the fact that significant disparities still exist in 2022 and 2023 points to the need for much greater efforts. Patients continue to report lack of available providers, inaccurate network directories, long wait times and denial of claims.

It is important to recognize that both private and public health insurers are now providing a relatively high

level of in-network access to the full range of specialty medical and surgical care for physical health diseases such as cancer, heart disease and diabetes. While there are shortages, in terms of the overall national supply, of many types of medical and surgical providers (including PCPs)—similar to the shortages of mental health and substance use providers—access to in-network care is substantially worse for mental health and substance use than for physical health. Achieving the same level of access to in-network mental health and substance use care as physical health in-network care is attainable and would greatly advance the goals of health equity and parity law compliance.

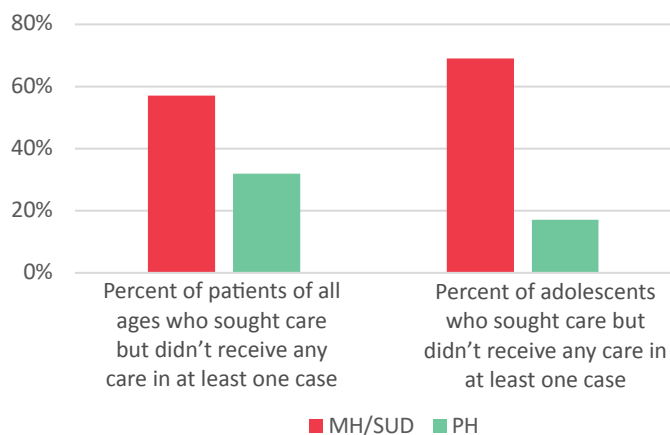
By addressing these critical priorities health system wide and nationwide, we can save lives, get Americans access to the care they deserve, help them recover, and ensure that mental illness will be detected and treated effectively for all Americans.

Addendum A: Detailed Survey Findings—Graphs

Sought but Did Not Receive Care (Neither In-network nor Out-of-network)

Patients had much greater difficulty accessing care for mental health or substance use conditions than for physical health conditions: 57% of those who sought mental health or substance use care didn't receive any care in at least one case, compared to 32% of those who sought physical health care (Fig. 2). This disparity widens for adolescents, where 69% of those who sought mental health or substance use care didn't receive any care in at least one case compared to 17% of those who sought physical health care.

Figure 2: Sought Care But Didn't Receive Any Care At Least Once



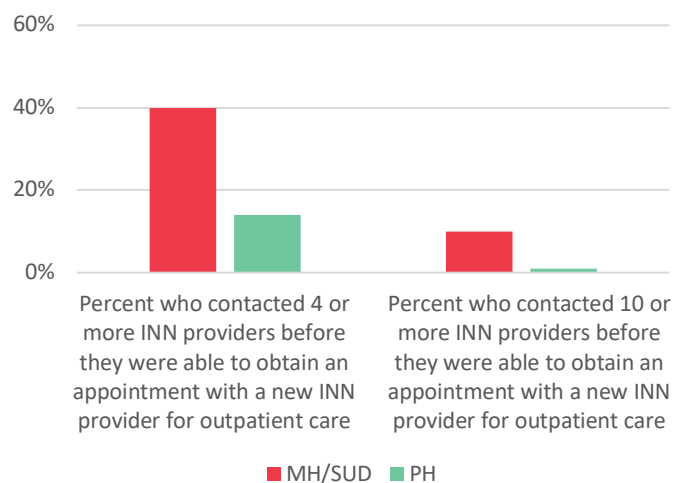
Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Obtaining an Appointment with New In-Network Providers

40% of patients using health insurance who received outpatient care from an in-network mental health or substance use provider, compared to 14% for physical health providers, had to contact 4 or more in-network providers before they were able to obtain an appointment with a new in-network provider (Fig. 3a). Furthermore, 10% of patients using health insurance who received outpatient care from an in-network mental health or substance use provider, compared to only 1% for physical health providers, had to contact 10 or more in-network providers before they were able to obtain an appointment with a new in-network provider—a 10-fold difference.

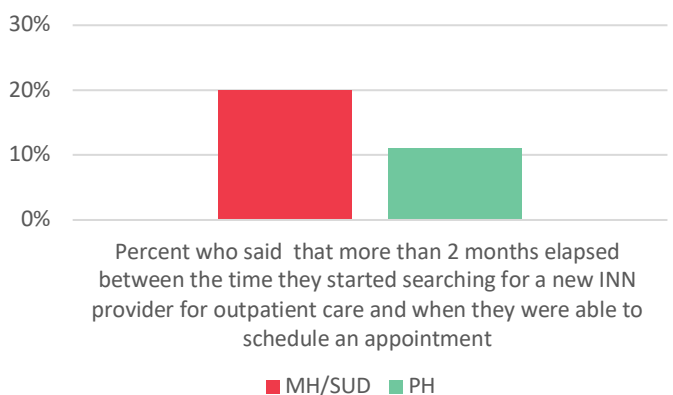
In terms of the time required to secure an appointment with a new in-network provider (“Search Time”), 20% of patients seeking mental health or substance use outpatient care reported that it took more than 2 months from the time they started searching until they were able to schedule an appointment (Fig. 3b). This figure was only 11% for

Figure 3a: Number of In-Network Providers Contacted Before Appointment Obtained



Note: INN=In-network; MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Figure 3b: Length of Time Between Seeking and Obtaining an Appointment (“Search Time”)



Note: INN=In-network; MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

patients seeking physical health outpatient care with a new in-network provider.

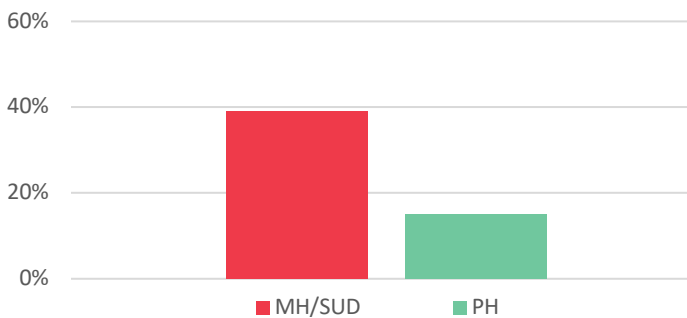
Use of Out-of-Network Providers

Use of out-of-network provider services was much higher for mental health or substance use care compared to physical health care. For example, for patients with employer-sponsored insurance plans (which frequently have out-of-network benefits), 39% used at least one out-of-network mental health or substance use provider for outpatient care compared to 15% for physical health providers (Fig. 4a). 80% of patients in employer-sponsored health plans who received outpatient care from at least one out-of-network mental health or substance use provider said they went to out-of-network providers “all of the time”, compared to just 6% of patients who said the same for physical health care. (Fig. 4b)

Use of out-of-network provider services was also greater for mental health/substance use care compared to physical health care among patients with individual private insurance plans: 43% received outpatient care from at least one out-of-network mental health or substance use provider versus 19% who received outpatient care from at least one out-of-network physical health provider (Fig. 4c). Of these patients, 47% reported using out-of-network mental health or substance use providers for outpatient care all of the

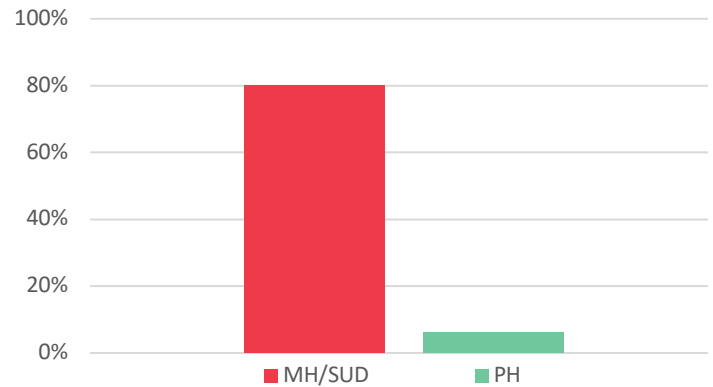
time, while only 9% reported using out-of-network physical health providers for outpatient care all of the time (Fig. 4d).

Figure 4a: Employer-Sponsored Plans: Percentage of Patients Who Received Care in an Outpatient Setting From At Least One Out-of-Network Provider



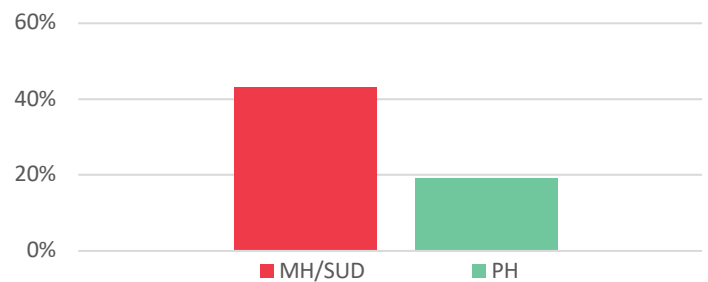
Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use. Source: Survey conducted by NORC, 2022

Figure 4b: Employer-Sponsored Plans: Among Patients Who Received Care in an Outpatient Setting From At Least One Out-of-Network Provider, Percentage Who Indicated that They Went to an Out-of-Network Provider “All Of The Time”



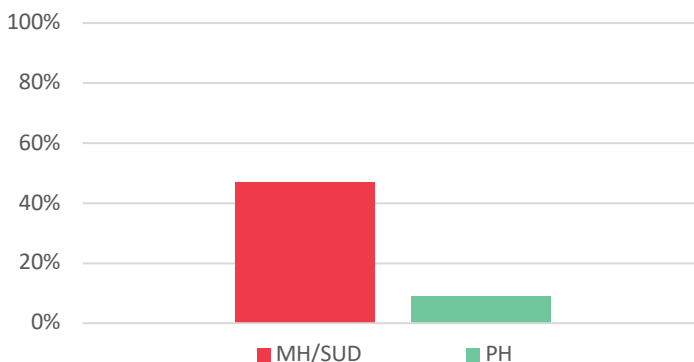
Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use. Source: Survey conducted by NORC, 2022

Figure 4c: Private Insurance Plan Purchased as an Individual: Percentage of Patients Who Received Care in an Outpatient Setting from At Least One Out-of-Network Provider



Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use. Source: Survey conducted by NORC, 2022

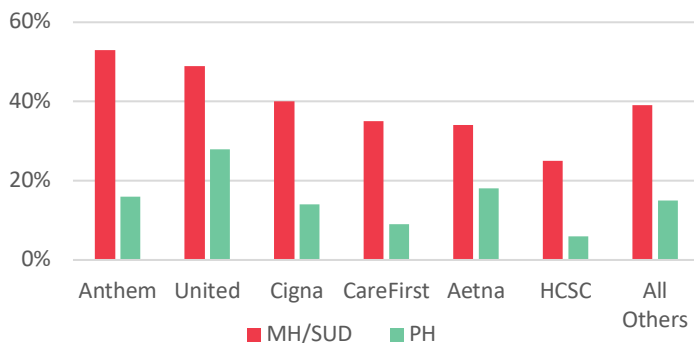
Figure 4d: Private Insurance Plan Purchased as an Individual: Among Patients Who Received Care in an Outpatient Setting from At Least One Out-of-Network Provider, Percentage Who Indicated that They Went to an Out-of-Network Provider “All Of The Time”



Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use. Source: Survey conducted by NORC, 2022

Figure 4e: Received Care In An Outpatient Setting From At Least One Out-of-Network Provider, By Insurance Company

(Employer-Sponsored and Individually Purchased Plans Combined)



Note: (a) MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health. (b) Mental health or substance use care received from mental health or substance use providers; physical health care received from physical health providers. (c) Typically, consumers have multiple types of physical health providers but only 1 or 2 mental health and/or substance use providers. (d) Commercial plan data includes both PPO type plans and HMO type plans. Out-of-network percentages for PPO plans (only) would show higher out-of-network use. “Anthem” includes Blue Cross and Blue Shield and affiliated blue plans in 14 states. “CareFirst” is a BlueCross BlueShield plan providing service in 3 areas. “United” includes Optum United Behavioral Health (“UBH”) and United Healthcare (“UHC”) combined. “HCSC” includes Blue Cross and Blue Shield plans in 5 states. Source: Survey conducted by NORC, 2022

Patients in both employer-sponsored plans and individually purchased private plans were asked to identify their insurance carriers. Across all major carriers, patients received substantially more mental health or substance use services out-of-network than physical health services (Fig. 4e), but with considerable variation among insurance carriers.

The Survey conducted by NORC (focusing now on employer-sponsored plans) and other studies described above have documented substantial disparities in out-of-network use between mental health/substance use and physical health care. Some industry participants have argued that the reasons for higher out-of-network use for mental health/substance use (a) relate to mental health/substance use patients preferring to go out-of-network for their care, (b) are different for mental health/substance use versus physical health care, and/or (c) are unrelated to network inadequacies for mental health/substance use. This Survey examined these 3 issues, as set forth below.

While a greater percentage of patients used out-of-network providers for mental health or substance use care than physical health care, the Survey found that the reasons for going out-of-network were similar for both mental health/substance use care and physical health care, and, contrary to arguments by some industry participants, do not explain the disparity in rates of out-of-network use. This was also the conclusion of Susan H. Busch and Kelly A. Kyanko in their [summary of research](#) (Busch & Kyanko, 2023).

For employer-sponsored plans, the reasons below for using out-of-network providers were cited by a majority of both mental health/substance use patients and physical health patients:

- Unable to find an in-network provider who was taking new patients
- Received a recommendation from a friend or a trusted provider to a specific out-of-network provider
- Already had a provider who was out-of-network and did not want to switch to a different provider
- Concerned about the quality of available in-network providers
- Providers listed in the network directory were not actually in the network or were no longer in the network

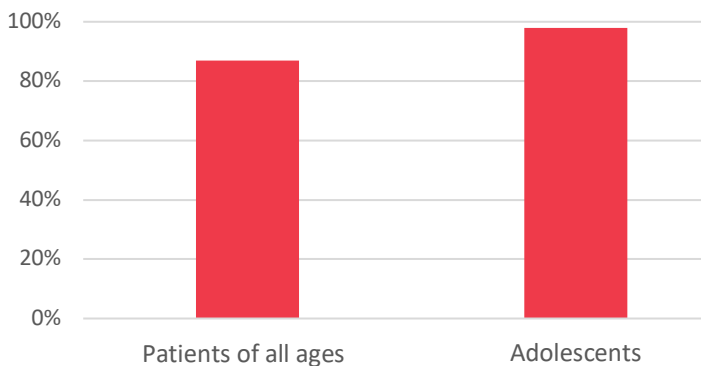
All of these reasons are indicators that mental health/substance use networks are inadequate when compared to physical health networks.

Mental Health and Substance Use Care by Physical Health Providers Is Viewed as Insufficient

The “Background” section of this report referenced data showing that more than half of patients who receive office-based mental health and substance use treatment receive it from primary care providers, and most psychiatric medication is prescribed by primary care providers. However, this “treatment as usual” is insufficient to address patients’ needs, which is why implementation of integrated care models is so important.

To gain perspective about the level of satisfaction with “treatment as usual” services, the Survey asked patients how satisfied they were with mental health or substance use treatment that they received from physical health providers: 87% of patients of all ages who received mental health or substance use care from physical health providers felt that they needed additional help from a mental health or substance use specialist. This figure was 98% for adolescent patients (Fig. 5a). Figures 5b and 5c show the results by insurance type and insurance carrier (which represents employer-sponsored plans and individual private insurance plans combined).

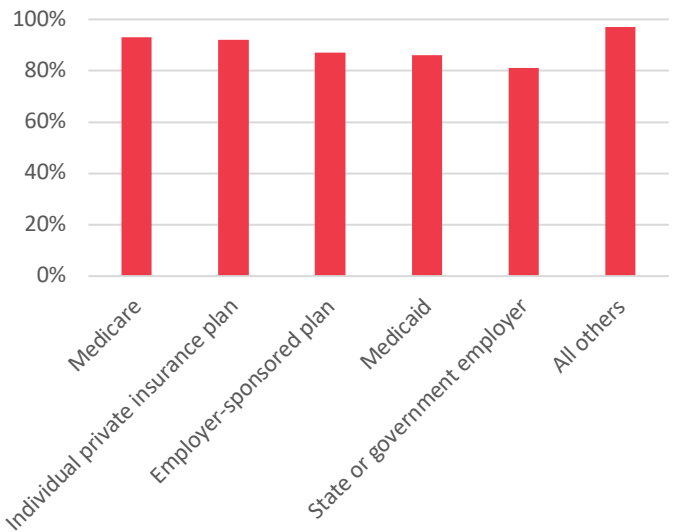
Figure 5a: Needed Additional Help From a Mental Health or Substance Use Specialist After Receiving Mental Health or Substance Use Care from Physical Health Providers



Percentage of patients who felt they *needed additional help* from a mental health or substance use specialist after receiving mental health or substance use care from physical health providers

Source: Survey conducted by NORC, 2022

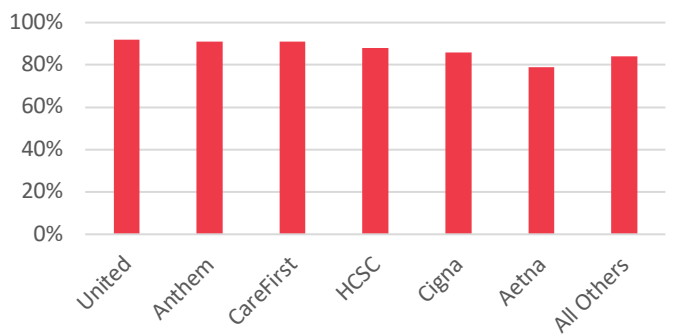
Figure 5b: Needed Additional Help From a Mental Health or Substance Use Specialist After Receiving Mental Health or Substance Use Care from Physical Health Providers – By Insurance Type



Source: Survey conducted by NORC, 2022

Figure 5c: Needed Additional Help From a Mental Health or Substance Use Specialist After Receiving Mental Health or Substance Use Care from Physical Health Providers – By Insurance Carrier

(Employer-Sponsored and Individually Purchased Plans Combined)



Source: Survey conducted by NORC, 2022

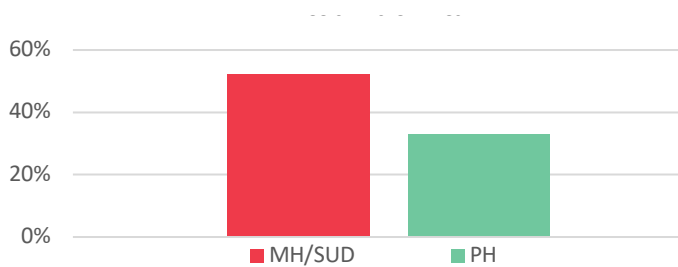
Denial of Claims

The Survey data showed that more claims were denied for mental health or substance use services compared to physical health services. For example, 52% of patients reported that their health insurance denied coverage three or more times for mental health or substance use services compared to 33% who reported the same for physical health services (Fig. 6a). Furthermore, of the patients who appealed denials, only 35% reported that mental health or substance use claim appeals were successful whereas 50% of patients reported that physical health claim appeals were successful (Fig. 6b).

65% of patients said that, overall, they had problems with their health insurance plan denying coverage for mental health and/or substance use care based on the following:

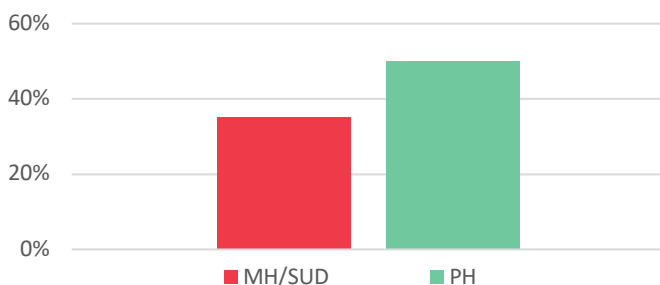
- Care deemed not medically necessary
- Care not being covered or excluded from coverage

Figure 6a: Percentage of Patients Who Reported that Their Health Insurance Denied Coverage Three or More Times



Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Figure 6b: Denial of Claims and Success of Appeals: Of Patients Who Appealed Denials, Percentage Who Indicated That Any of the Appeals Were Successful



Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Use of Insurance to Pay for Outpatient Care

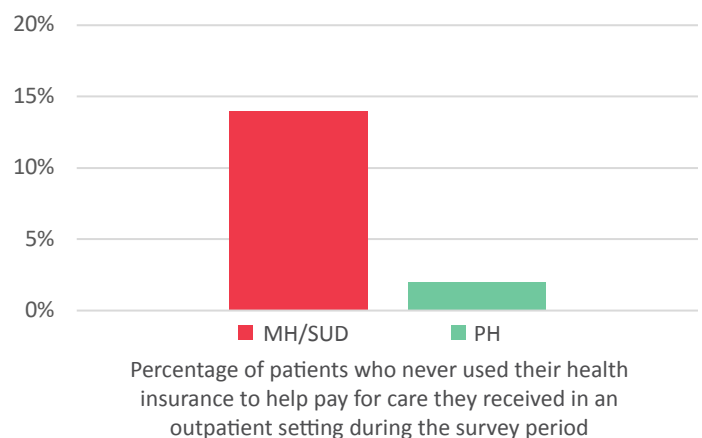
A substantial percentage of patients seeking outpatient mental health or substance use services never used their health insurance to pay for these services during the survey period (14% for mental health/substance use versus 2% for physical health) (Fig. 7).

Following are the primary reasons why patients with insurance did not use their insurance for mental health or substance use services (Note: Physical health not reported here due to small sample size):

- The provider I wanted to go to did not accept my insurance: **49%**
- My insurance did not include coverage for the treatment services I was seeking: **20%**
- It was easier/less troublesome to not use insurance: **7%**
- I did not want my employer/parent/spouse/other to know that I was seeking certain types of treatment: **3%**

The top two reasons highlight gaps in access to mental health and substance use coverage—either the provider did not accept the patient’s insurance or the services were not covered by their insurance. In contrast, very few patients decided not to use their insurance in order to avoid having their employers learn about their mental health or substance use care.

Figure 7: Patients Received Care But Did Not Use Insurance During the Survey Period



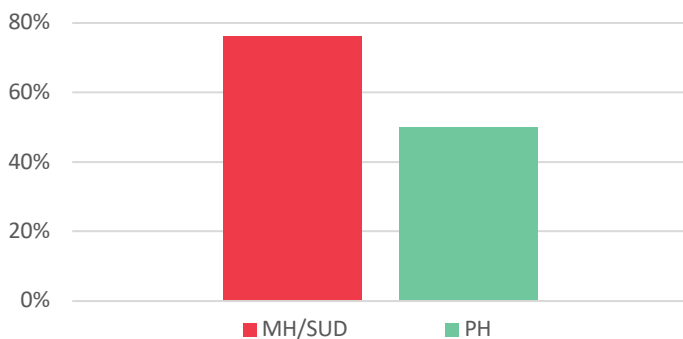
Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Impact of COVID-19

The “Background” section of this report described the long-term trend of increasing incidence of mental health and substance use conditions, suicides and deaths, particularly among adolescents and young adults.

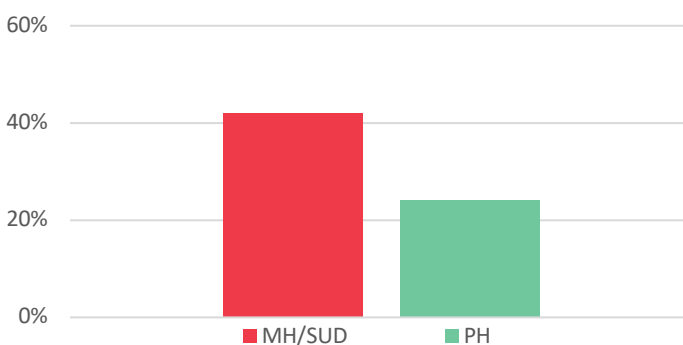
The Survey showed that the COVID-19 pandemic exacerbated this trend for mental health or substance use: 76% of patients said that their mental health or substance use condition worsened during COVID-19, compared to 50% who said that their physical health condition worsened during COVID-19 (Fig. 8a). Of these patients, 42% said that their mental health or substance use condition became “much worse,” compared to 24% who said the same for their physical health condition. (Fig. 8b)

Figure 8a: Impact of COVID-19 on Health: Percentage of Patients Who Reported that Their Health Condition Worsened During the COVID-19 Pandemic



Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Figure 8b: Impact of COVID-19 on Health: Of Patients Who Reported that Their Health Condition Worsened During the COVID-19 Pandemic, Percentage Who Reported that Their Condition Became “Much Worse”



Note: MH=Mental Health; SUD=Substance Use Disorder; PH=Physical Health
Source: Survey conducted by NORC, 2022

Tele-Behavioral Health

For mental health, substance use, and physical health care, many payers instituted or expanded telehealth benefits as an alternative to in-person services during the early COVID-19 period. Even as COVID-19 has abated, society’s service-delivery structure has trended more and more to online services across many industries. To evaluate patients’ perception of the efficacy and benefit of telehealth services, the Survey asked patients to rate telehealth compared to in-person services. Specifically, the Survey inquired about tele-behavioral health for mental health or substance use conditions compared to in-person services for mental health or substance use conditions.

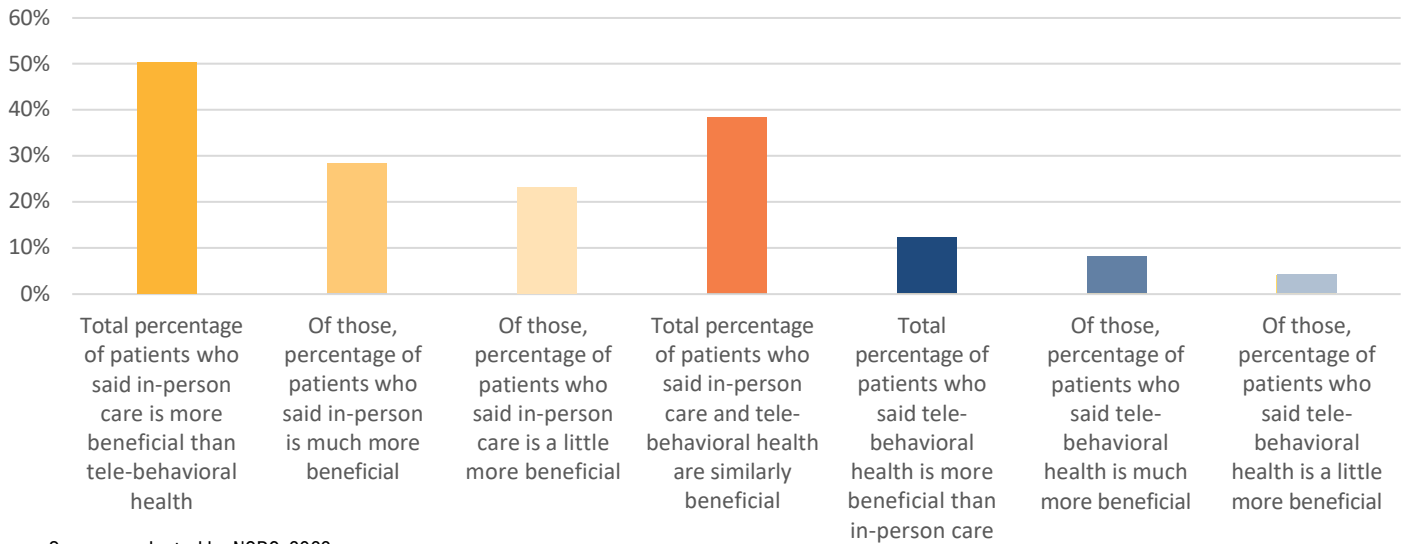
50% of patients reported that in-person care is more beneficial than tele-behavioral health (Fig. 9). Of this group, 28% said in-person care is much more beneficial and 23% said in-person care is a little more beneficial than tele-behavioral health. 38% of patients said that tele-behavioral health and in-person care are similarly beneficial, and 12% said that tele-behavioral health is more beneficial than in-person care. Of the latter group, 8% said that tele-behavioral health is much more beneficial and 4% said that tele-behavioral health is a little more beneficial than in-person care.

Exploring patient views of the value of tele-behavioral health, the Survey asked patients if they thought tele-behavioral health was helpful. 72% of patients reported that using interactive tele-behavioral health with a provider helped.

The Survey also asked patients about their preferences regarding audio, video, and texting when using tele-behavioral health.

- 63% of patients preferred audio-video tele-behavioral health versus audio-only tele-behavioral health
- 27% of patients preferred audio-only (phone calls) or had no preference between video and audio. However:
 - 42% of patients enrolled in Medicaid preferred audio-only (phone calls) or had no preference between video and audio
 - 44% of Black/African American patients preferred audio-only (phone calls) or had no preference between video and audio
- 48% of patients said that they probably or definitely would use texting to interact with mental health or substance use providers:

Figure 9: Perception of Tele-Behavioral Health Versus In-Person Services



Source: Survey conducted by NORC, 2022

- 58% of Black/African American patients said that they probably or definitely would use texting to interact with mental health or substance use providers

This data provides a compelling argument for insurers to reimburse audio-video and audio-only tele-behavioral health at the same level as in-person visits, and to reimburse for provider-patient texting to improve health equity.

App-based Behavioral Health Tools

While a typical tele-behavioral health application involves video or audio interaction with a provider, many apps on smartphones and computers that do not involve a provider are being increasingly used to assist patients with mental health and/or substance use conditions. The Survey asked about patient preferences and needs regarding the use of such apps, and found that:

- 64% of patients said that using behavioral health smartphone or computer apps that do not involve a provider helped
 - 77% of Black/African American patients said that using behavioral health smartphone or computer apps that do not involve a provider helped
- 78% of patients said it would be helpful if there was an objective information source that could tell them what behavioral health smartphone or computer apps are actually effective for people like them
- 85% of patients said it would be helpful if their insurer would pay for a range of tele-behavioral health smartphone or computer apps, so that they (or their provider) could select from a broad list that has been shown to help many people

Addendum B: Detailed Survey Findings—Master Table

		Mental Health/ Substance Use	Physical Health
2	2. Percentage of patients of all ages who sought care but didn't receive any care in at least one case	57%	32%
	<ul style="list-style-type: none"> Percentage of adolescents who sought care but didn't receive any care in at least one case 	69%	17%
3	3a. Percentage of patients using health insurance who received outpatient care from an in-network provider but had to contact 4 or more in-network providers before they were able to obtain an appointment with a new in-network provider	40%	14%
	<ul style="list-style-type: none"> Percentage of patients using insurance who received outpatient care from an in-network provider but had to contact 10 or more in-network providers before they were able to obtain an appointment with a new in-network provider 	10%	1%
	3b. Percentage of patients who said that over 2 months elapsed between the time they started searching for a new in-network provider for outpatient care and when they were able to schedule an appointment	20%	11%
4	4a. Percentage of patients in <u>employer-sponsored</u> health plans who used at least one out-of-network provider for outpatient care	39%	15%
	4b. Among patients in <u>employer-sponsored</u> health plans who received outpatient care from at least one out-of-network provider, percentage who said they went to an out-of-network provider "all of the time"	80%	6%
	4c. Percentage of patients with <u>individual</u> private insurance plans who used at least one out-of-network provider for outpatient care	43%	19%
	4d. Among patients with <u>individual</u> private insurance plans who received outpatient care from at least one out-of-network provider, percentage who said they went to an out-of-network provider "all of the time"	47%	9%
	4e. Among large insurers (employer-sponsored health plans <u>and</u> individual private insurance plans combined), the use of out-of-network providers percentages were:		
	<ul style="list-style-type: none"> Anthem 	53%	16%
	<ul style="list-style-type: none"> United 	49%	28%
	<ul style="list-style-type: none"> Cigna 	40%	14%
	<ul style="list-style-type: none"> CareFirst 	35%	9%
	<ul style="list-style-type: none"> Aetna 	34%	18%
<ul style="list-style-type: none"> HCSC 	25%	6%	
<ul style="list-style-type: none"> All others 	39%	15%	
	For employer-sponsored health plans, reasons cited by a majority of both mental health/substance use patients and physical health patients:		
	<ul style="list-style-type: none"> Unable to find an in-network provider who was taking new patients 		
	<ul style="list-style-type: none"> Received a recommendation from a friend or a trusted provider to a specific out-of-network provider 		
	<ul style="list-style-type: none"> Already had a provider who was out-of-network and did not want to switch to a different provider 		
	<ul style="list-style-type: none"> Concerned about the quality of available in-network providers 		
	<ul style="list-style-type: none"> Providers listed in the network directory were not actually in the network or were no longer in the network 		

		Mental Health/ Substance Use	Physical Health
5	5a. Percentage of patients of all ages who received mental health or substance use care from physical health providers who felt that they needed additional help from a mental health or substance use specialist	87%	
	<ul style="list-style-type: none"> Percentage of adolescents who received mental health or substance use care from physical health providers who felt that they needed additional help from a mental health or substance use specialist 	98%	
	5b. Percentage of patients who received mental health or substance use care from physical health providers who felt that they needed additional help from a mental health or substance use specialist— <u>by insurance type:</u>		
	<ul style="list-style-type: none"> Medicare 	93%	
	<ul style="list-style-type: none"> Individual private insurance plan 	92%	
	<ul style="list-style-type: none"> Employer-sponsored plan 	87%	
	<ul style="list-style-type: none"> Medicaid 	86%	
	<ul style="list-style-type: none"> State or government employer 	81%	
	<ul style="list-style-type: none"> All others 	97%	
	5c. Percentage of patients who received mental health or substance use care from physical health providers who felt that they needed additional help from a mental health or substance use specialist— <u>by insurance carrier</u> (employer-sponsored health plans <u>and</u> individual private insurance plans combined):		
	<ul style="list-style-type: none"> United 	92%	
	<ul style="list-style-type: none"> Anthem 	91%	
	<ul style="list-style-type: none"> CareFirst 	91%	
<ul style="list-style-type: none"> HCSC 	88%		
<ul style="list-style-type: none"> Cigna 	86%		
<ul style="list-style-type: none"> Aetna 	79%		
<ul style="list-style-type: none"> All Others 	84%		
6	6a. Percentage of patients who reported that their health insurance denied coverage 3 or more times	52%	33%
	6b. Of patients who appealed denials, percentage who indicated that any of the appeals were successful	35%	50%
	Percentage of patients who said that, overall, they had problems with their health insurance plan denying coverage for mental health and/or substance use care based on either (1) the care not being medically necessary or (2) the care being not covered or excluded from coverage	65%	
7	7. Percentage of patients who never used their health insurance to pay for outpatient care during the survey period	14%	2%
	Primary reasons why patients did not use their insurance for mental health or substance use services (Note: Physical health not reported due to small sample size):		
	<ul style="list-style-type: none"> The provider I wanted to go to did not accept my insurance 	49%	
	<ul style="list-style-type: none"> My insurance did not include coverage for the treatment services I was seeking 	20%	
	<ul style="list-style-type: none"> It was easier/less troublesome to not use insurance 	7%	
<ul style="list-style-type: none"> I did not want my employer/parent/spouse/other to know that I was seeking certain types of treatment 	3%		

		Mental Health/ Substance Use	Physical Health
8	8a. Percentage of patients who reported that their health condition worsened during the COVID-19 pandemic	76%	50%
	8b. Of patients who reported that their health condition worsened during the COVID-19 pandemic, percentage who reported that their condition became “much worse”	42%	24%
9	9. Percentage of patients who said in-person care is more beneficial than tele-behavioral health	50%	
	• Percentage who said in-person is much more beneficial	28%	
	• Percentage who said in-person is a little more beneficial	23%	
	Percentage of patients who said in-person care and tele-behavioral health are similarly beneficial	38%	
	Percentage of patients who said tele-behavioral health is more beneficial than in-person care	12%	
	• Percentage who said tele-behavioral health is much more beneficial	8%	
	• Percentage who said tele-behavioral health is a little more beneficial	4%	
	Percentage of patients who said that using interactive tele-behavioral health involving a provider helped	72%	
	Percentage of patients who preferred video tele-behavioral health as compared to audio	63%	
	Percentage of patients who preferred phone calls (audio only) or had no preference between video and phone calls	27%	
	• Percentage of Medicaid patients who preferred phone calls (audio only) or had no preference between video and phone calls	42%	
	• Percentage of Black/African American patients who preferred phone calls (audio only) or had no preference between video and phone calls	44%	
	Percentage of patients who said that they probably or definitely would use texting to interact with mental health or substance use providers	48%	
	• Percentage of Black/African American patients who said that they probably or definitely would use texting to interact with mental health or substance use providers	58%	
	Percentage of patients who said that using behavioral health smartphone or computer apps helped	64%	
	• Percentage of Black/African American patients who said that using behavioral health smartphone or computer apps helped	77%	
	Percentage of patients who said it would be helpful if there was an objective information source that could tell them what behavioral health smartphone or computer apps have actually been effective for people like them	78%	
Percentage of patients who said it would be helpful if their insurer would pay for a range of tele-behavioral health smartphone or computer apps, and they (or their provider) could select from a broad list that has been shown to help many people	85%		

Appendix 1: Other Studies Examining Network Adequacy

The studies highlighted below, including five that were conducted in 2022 and 2023, demonstrate the continuation of major mental health and substance use access issues that have existed for decades. All of the research methods—whether surveys of various stakeholders or claims data—reveal results consistent with each other and the Survey conducted by NORC:

Surveys of employers

- The recently released [Voice of the Purchaser](#) survey of 220 employers conducted in 2023 by the [National Alliance of Healthcare Purchasers Coalition](#) and the [HR Policy Association](#) (National Alliance of Healthcare Purchaser Coalitions, 2023). In this survey, employers were asked to rate the level of importance of various aspects of mental health and substance use care to their organization and satisfaction with their vendors' (e.g., third party administrators) performance related to these issues:
 - “While 99% agreed that effective and timely access to in-network behavioral health providers is important, only 31% were satisfied...”
 - “Only 34% of employers agreed that their behavioral health directories accurately reflect the providers available to plan participants...”
 - “84% agreed that it was important that plans support, promote and incentivize integration of behavioral health into primary care, but only 28% were satisfied.”
- The 2022 [survey of 2,188 employers](#) conducted by the Kaiser Family Foundation (Claxton et al., 2022) stated:

“We also asked employers about whether there were enough providers in the network of their plan with largest enrollment for enrollees to receive timely access to services. Eighty-two percent of employers said that this plan had enough primary care providers to provide timely access to services, but only 44 percent said that this network had enough behavioral care providers to

provide sufficient access to services, and 32 percent of employers said that they did not know.”

Other surveys of patients

- [Susan H. Busch and Kelly A. Kyanko: Network Access and Adequacy—Summary of Published and Unpublished Research 2018-2023](#) (Busch & Kyanko, 2023)

In their seminal work evaluating access within commercial insurer networks, Busch and Kyanko employed an online panel of approximately 50,000 households, oversampled participants who used mental health providers and out-of-network providers, and applied weights to match respondents to the U.S. population based on demographic characteristics and to account for panel recruitment, attrition, oversampling, and survey non-response:

- “...among patients receiving both mental health and medical/surgical care, many more patients used an out-of-network mental health provider (33% versus 19%)...”
- “Differences in out-of-network health care use likely underestimate the extent of mental health network inadequacy.”
- “...the high rates of [out-of-network] mental health compared to [out-of-network] medical/surgical care are not primarily due to differences in the reasons individuals use [out-of-network] mental health providers.”

Surveys of providers

- [Senate Committee on Finance, Majority Staff Secret Shopper study](#) of 2023 (Senate Committee on Finance Majority, 2023). Staff called 120 providers listed in the directories of 12 Medicare Advantage plans across 6 states to determine how difficult it is to secure in-network mental health care for an older adult with depression enrolled in a Medicare Advantage plan. Among their key findings:

- More than 80% of the providers called were either unreachable, not accepting new patients, or not in-network
- 33% had inaccurate or non-working numbers, or resulted in unreturned calls
- An appointment could be made with only 18% of the providers called

More than 80% of the providers called were either unreachable, not accepting new patients, or not in-network

The committee concluded “It is particularly troubling to consider how this report’s findings may acutely affect an individual struggling with a mental health condition and attempting to navigate the process of identifying an in-network provider in a directory where 80% of the listed providers are inaccurate or unavailable”.

- Healthy Minds (Oklahoma) In February 2023, Healthy Minds Policy Initiative released data from a [large-scale investigation](#) into Oklahoman’s access to behavioral health providers through private insurance plans (Healthy Minds Policy Initiative, 2023). Findings show that substantial barriers to access exist. Following are report highlights:

- “The majority of behavioral health providers listed by insurance networks appear unavailable or unreachable—many with disconnected phone lines.”
- “Even when behavioral health providers are active in the network, many cannot see clients in a timely manner.”
- “Insurance plans leave out the vast majority of available providers. In the best example, only 30% of behavioral health providers are in network.”

The study concluded that insurance networks omit between 63-71% of psychiatrists and 66-67% of substance use treatment providers in the state.

Commercial Insurance Claims Analyses

- The 2020 [Milliman high-cost report](#) (Davenport, et al., 2020) covering 21 million lives found that:
 - 5.7 million individuals had behavioral health diagnoses. Among these patients, 50% (or 2.8 million individuals) received minimal or no behavioral care in 2017—incurring less than \$68 in annual costs for behavioral health treatment.
- The 2019 [Milliman claims data disparity report](#) (Melek, et al., 2019) covering 39 million lives reported:

- “[From 2013 to 2017], the disparity for behavioral health office visits relative to medical/surgical primary care office visits has increased from 5.0 times (500%) more likely to 5.4 times (540%) more likely...”
- “As of 2017, primary care reimbursements were 23.8% higher than behavioral reimbursements, which is an increase from 20.8% higher in 2015... for 11 states, reimbursement rates for primary care office visits were more than 50% higher than reimbursement rates for behavioral office visits, an increase from 9 states in 2015.”
- “In 2017, a behavioral healthcare office visit for a child was 10.1 times more likely to be to an out-of-network provider than a primary care office visit—this was more than twice the disparity seen for adults.”
- The 2018 [claims data study](#) (Mark et al., 2018) by authors at RTI International, Truven Health Analytics, and SAMHSA analyzed 3.8 million patients with a mental disorder as their primary diagnosis:
 - “Psychiatrists receive lower in-network reimbursement [between 13% and 20% less] than non-psychiatrist medical doctors for many of the same services. This may contribute to psychiatrists’ lower participation in insurance networks relative to other providers and has implications for patient cost sharing and access to psychiatrists.”

This overwhelming evidence of significant lack of access to specialty mental health and substance use care, which has existed for decades and is continuing in 2023, coupled with escalating rates of suicide and overdoses (Warren, 2022), makes clear that lack of access to effective mental health and substance use care is a staggering public health challenge.

Appendix 2: Excerpts from Milliman High-Cost Study

Average Annual Healthcare Treatment Costs (Services and Prescription Drugs) per Individual by Behavioral Health Category, 2017 Total Population (21 Million Patients)

BH CATEGORY*	AVERAGE ANNUAL HEALTHCARE COSTS			COSTS RELATIVE TO NO BH	
	TOTAL	BEHAVIORAL HEALTH	MEDICAL/ SURGICAL	TOTAL	MEDICAL/ SURGICAL
No BH	\$3,552	\$0	\$3,552	1.0x (ref)	1.0x (ref)
Any BH (MH and/or SUD)	\$12,272	\$965	\$11,307	3.5x	3.2x
Any MH	\$12,221	\$1,017	\$11,204	3.4x	3.2x
MH, not SMI	\$11,856	\$789	\$11,067	3.3x	3.1x
MH, SMI	\$22,460	\$7,422	\$15,038	6.3x	4.2x
MH, without SUD	\$10,855	\$772	\$10,083	3.1x	2.8x
Any SUD	\$19,796	\$1,989	\$17,807	5.6x	5.0x
SUD, without MH	\$12,923	\$303	\$12,619	3.6x	3.6x
Both MH and SUD	\$25,602	\$3,413	\$22,189	7.2x	6.2x
Total Population	\$5,932	\$263	\$5,669	1.7x	1.6x

*Note that the "MH, not SMI" and "MH, SMI" categories include some individuals who also have substance use disorders.

Source: Davenport, et al., 2020

Definitions: BH=Behavioral Health; MH=Mental Health; SUD=Substance Use Disorder; SMI=Serious Mental Illness

Appendix 3: List of Organizations that Distributed the Survey Link

- American Foundation for Suicide Prevention—GA
- American Psychiatric Association
- American Psychological Association
- Anxiety and Depression Association of America
- Association for Behavioral and Cognitive Therapies
- Community Catalyst
- Eating Disorders Coalition for Research, Policy, & Action
- Florida Alliance for Healthcare Value
- Georgia Psychological Association
- The Kennedy Forum
- Legal Action Center
- Mental Health America
- Mental Health Association of Maryland
- Minnesota Health Leadership Council
- NAMI, National Alliance on Mental Illness
- National Association of Addiction Treatment Providers
- National Council for Mental Wellbeing
- Northeast Business Group on Health
- Northwestern University, Center for Behavioral Intervention Technologies
- Pennsylvania Psychological Association
- One Mind PsyberGuide
- REDC Consortium
- Shatterproof
- Tennessee Psychological Association
- The Jed Foundation
- Treatment Advocacy Center

Appendix 4: Survey Methodology and Types of Insurance

The Survey was designed to elicit information regarding the experiences of patients seeking access to in-network health-care services. As noted earlier, the methodology included convenience sampling based on people who responded to notices about the Survey from a range of organizations, which are listed in Appendix 3.

2,794 responses to the Survey were received, all regarding patients who needed mental health and/or substance use care during the period beginning January, 2019 through

April, 2022. Patients were asked about their experience accessing their mental health and/or substance use care and also their physical health care. 48% of responses were from patients completing the Survey on their own, and 52% of responses were by family members, friends, providers, or others on behalf of patients (including all patients under 18). In this report, when reference is made to responses by patients, this means responses by patients or by others on behalf of patients.

Demographics of Survey Patients:

GENDER		RACE		AGE	
Male	36%	White	82%	Under 18	6%
Female	61%	Black or African American	9%	18—21 years	6%
Transgender	2%	Asian	3%	22—26 years	11%
Do not identify as male, female, or transgender	2%	All others	6%	27—54 years	57%
		Hispanic Origin*	Yes 7%	55—64 years	13%
			No 93%	Over 65 years	8%

*For patients who identified themselves as White, these figures were 5% “Yes” and 95% “No”.

Types of Insurance Analyzed:

Type of Insurance	Percentage of patients with insurance type
Employer-Sponsored Plan	47%
Private insurance purchased as an individual (including healthcare.gov)	6%
Medicaid	17%
Medicare	12%
TRICARE	1%
Federal Employee Health Benefits Program (FEHBP)	2%
State or local government employer insurance	10%
VA health benefits	1%
Student health plan	1%
Other	2%

Note: All Survey percentages throughout this report include all insurance types (combined) unless otherwise noted.

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