

441 G St. N.W.
Washington, DC 20548

March 31, 2021

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate

Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID-19 Pandemic

Dear Mr. Chairman:

Behavioral health conditions, which include mental health and substance use disorders, affect a substantial number of adults in the United States.¹ For example, in 2019, an estimated 52 million adults in the United States (21 percent) were reported to have a mental, behavioral, or emotional disorder.² Additionally, 20 million people aged 12 or older had a substance use disorder (either an alcohol use disorder, an illicit drug use disorder, or both). Experts have expressed concerns that the incidence of behavioral health conditions would increase as a result of stressors associated with the COVID-19 pandemic—such as social isolation and job loss—and, in November 2020, we reported early evidence of increases in these conditions linked to the pandemic. We also reported that the behavioral health workforce may face challenges managing the increased demand for services.³

The growing demand for behavioral health services underscores the importance of having health coverage for these services. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 generally requires that coverage for mental health and substance use disorder be no more restrictive than coverage for medical/surgical services.⁴ State agencies and the Departments of Labor (DOL) and Health and Human Services (HHS)

¹Examples of mental health conditions are anxiety disorders, including post-traumatic stress disorder; mood disorders, including depression and bipolar disorder; and schizophrenia. Examples of substance use disorders are alcohol use disorder and opioid use disorder.

²See Substance Abuse and Mental Health Services Administration (SAMHSA), *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*, (Rockville, M.D.: September 2020). SAMHSA classified adults aged 18 or older as having any mental illness if they had any mental, behavioral, or emotional disorder in the past year of sufficient duration to meet criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (excluding developmental disorders and substance use disorders). SAMHSA classified adults with any mental illness as having serious mental illness if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities. In its estimates of those with a substance use disorder, SAMHSA included those reporting an alcohol use disorder, illicit drug use disorder, or both in the past year. The survey excludes people with no fixed address, military personnel on active duty, and residents of institutional facilities such as nursing homes and prisons.

³See *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, [GAO-21-191](#) (Washington, D.C.: Nov. 30, 2020).

⁴Pub. L. No. 110-343, Div. C, Tit. V, Sub. B, §§ 511-512, 122 Stat. 3765, 3881-3893 (Oct. 3, 2008).

share responsibility for overseeing compliance with these parity requirements among group and individual health plans.⁵ However, even before the pandemic, long-standing questions were raised about whether coverage or claims for behavioral health services are denied or delayed at higher rates than those for other health services. For example, in a 2019 class action lawsuit, a federal district court ruled that United Behavioral Health had adopted behavioral health service coverage guidelines inconsistent with the standard of care and had improperly denied the plaintiffs benefits for such services.⁶ In another example, in 2018 the New York Attorney General's office reported that, since 2013, it had levied \$3 million in penalties on health plans and secured over \$2 million in reimbursements to patients for out of pocket expenses that should have been covered by the health plan.⁷

You asked us to examine several issues related to the demand for behavioral health services as well as coverage and payment for these services. This report describes

(1) what is known about the need for and availability of behavioral health services, and how these have changed during the COVID-19 pandemic; and

(2) what issues selected stakeholders identified regarding the payment of claims for behavioral health services.

To examine what is known about the need for and availability of behavioral health services and how they have changed during the pandemic, we reviewed relevant survey data and analyses. Specifically, we reviewed data from Phases 1, 2, and 3 of the Household Pulse Survey through February 15, 2021, as reported by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, which includes questions on the frequency of anxiety and depression symptoms. We assessed the reliability of these data by reviewing relevant agency documentation and written information from agency officials and by checking for obvious errors. We determined that these data were sufficiently reliable for the purpose of describing reported effects of the COVID-19 pandemic on behavioral health symptoms and demand for treatment. We also reviewed the findings from the National Council for Behavioral Health's (NCBH) survey of its members—including entities that provide behavioral health services—conducted in August 2020 and February 2021 and assessed the reliability of these data by requesting information from NCBH and reviewing survey documentation.⁸ We determined that these data were sufficiently reliable for the purpose of describing reported effects of the COVID-19 pandemic on behavioral health treatment providers. We also leveraged our recent work that examined data from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Disaster

⁵For more information see GAO, *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies*, [GAO-20-150](#) (Washington, D.C.: Dec. 13, 2019).

⁶See *Wit v. United Behavioral Health*, Case No. 14-cv-02346-JCS, 2019 WL 1033730 (N.D. Cal., Mar. 5, 2019).

⁷See New York State Office of the Attorney General, *Mental Health Parity: Enforcement by the New York State Office of the Attorney General* (New York: 2018).

⁸NCBH represents health care organizations and health care management entities providing treatment and support in the community to adults, children, and families living with mental illnesses and addictions. The first survey was conducted between August 17 and September 1, 2020, among a national sample of 343 NCBH members. The second was conducted between February 1 and 18, 2021, among a national sample of 332 NCBH members. Both surveys were conducted online and the results had a margin of error of plus or minus 5 percent.

Distress Helpline and National Helpline data provided for January through August 2019 and January through August 2020.⁹

Additionally, we interviewed various other stakeholders, including officials from insurance regulators and hospital associations in four states—Oregon, Pennsylvania, Texas, and Virginia—and officials from one hospital system in Oregon to gain a better understanding of how these issues affected providers at the state-level and to identify examples of issues regarding payment of claims for behavioral health services.¹⁰ We selected these states for variation in geographic location, and because they were identified as actively assessing mental health parity issues or how behavioral health service payments compare to that of other services, either based on recent publicly available information or input from the National Association of Insurance Commissioners (NAIC).¹¹

To further examine issues regarding the payment of claims for behavioral health services, we reviewed three publicly available reports from Virginia that compared claims for behavioral health services with that of other services. We also asked officials from all the stakeholder organizations we interviewed whether they were aware of any data or analysis that corroborate their views. As a result, we identified and reviewed an additional analysis conducted in Texas that compared claims for behavioral health services with that of other health services. We also considered the evidence collected in the context of prior GAO work examining mental health parity issues. Beyond the state-level review, we also interviewed officials from NCBH to obtain their perspectives about their members' experiences with behavioral health service claims denials or delays.

We conducted this performance audit from February 2021 through March 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Longstanding Unmet Needs for Behavioral Health Services Persist and Were Worsened by New Challenges Associated with the COVID-19 Pandemic

There have been longstanding concerns about the availability of behavioral health treatment, particularly for low-income individuals, given the demand for these services. For example, in 2015, we reported statistics on the incidence of behavioral health conditions and the status of the behavioral health workforce.¹² Specifically, as noted in our report, SAMHSA estimated that in 2013 there were 3.9 million adults aged 18 or older with a serious mental illness who

⁹See [GAO-21-191](#).

¹⁰We also interviewed the Pennsylvania Rehabilitation and Community Providers Association, a trade association that represents providers that address mental health, drug and alcohol treatment, brain injury, aging, and other issues.

¹¹NAIC is a voluntary association of the chief insurance regulators from all 50 states, the District of Columbia, and five U.S. territories. NAIC coordinates the regulation of multistate insurers, develops standards for state insurance regulation, and publishes model laws, regulations, and guidelines that state regulators can use as resources for developing their laws and regulations. In addition, NAIC provides a forum for states to share information and state-developed tools, as well as to discuss issues with federal regulators.

¹²See GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, [GAO-15-449](#) (Washington, D.C.: June 19, 2015).

perceived an unmet need for mental health care within the prior 12 months. This number included an estimated 1.3 million adults with a serious mental illness who did not receive any mental health services. As we reported in 2015, one potential barrier to accessing treatment has been shortages of qualified behavioral health professionals, particularly in rural areas. For example, SAMHSA noted that in 2013 more than three quarters of counties in the United States had a serious shortage of mental health professionals.

These workforce shortages are expected to continue. For example, before the COVID-19 pandemic, the Health Resources and Services Administration (HRSA) reported that, by 2025, shortages of seven selected types of behavioral health providers were expected, with shortages of some provider types expected to exceed 10,000 full-time equivalents.¹³ Additionally, as of September 30, 2020, HRSA designated more than 5,700 mental health provider shortage areas, with more than one-third of Americans (119 million people) living in these shortage areas. In these areas, the number of mental health providers available were adequate to meet about 27 percent of the estimated need.¹⁴

All stakeholders we spoke with agreed that meeting the demand for behavioral health services has been a longstanding problem, citing reasons such as workforce shortages, provider reimbursement rates, and health system capacity. For example:

- NCBH officials told us that its members maintain patient waiting lists and have problems with staff turnover and retention, noting that staff turnover at clinics both results in fewer staff on hand to treat patients and imposes additional training costs for new hires. The officials noted workforce retention has been a priority for NCBH members.
- Officials from the Texas Department of Insurance also noted a general shortage of behavioral health providers, especially those willing to contract with health plans, in part because of low reimbursement rates.
- Representatives from the state hospital associations noted similar, longstanding concerns within their states. For example, officials from the Virginia Hospital & Healthcare Association shared that, prior to the pandemic, its members faced workforce challenges that made it hard to hire sufficient employees to staff the licensed behavioral health hospital beds within their system. Further, officials from the hospital associations in two states—Virginia and Oregon—noted that the lack of a sufficient community-based behavioral health workforce in their states led to longer hospital in-patient stays for patients, who would otherwise be able to be treated in more appropriate settings.

Recent reports from two of the states in our review—Pennsylvania and Oregon—further documented problems with meeting the need for behavioral health services in their states that

¹³See Health Resources and Services Administration, National Center for Health Workforce Analysis, *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025* (Rockville, M.D.: November 2016). A total of nine types of behavioral health practitioners were considered in these estimates: psychiatrists; behavioral health nurse practitioners; behavioral health physician assistants; clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; school counselors; and marriage and family therapists. These professions were chosen because they have the largest number of providers within behavioral health care.

¹⁴HRSA computes the percent of need met by dividing the number of mental health providers available to serve the population of the area, group, or facility by the number of mental health providers necessary to reduce the population-to-provider ratio below the threshold that would allow it to eliminate the designation as a Health Professional Shortage Area for mental health.

existed before the pandemic. Specifically, in 2019, Pennsylvania’s Joint State Government Commission was directed by the General Assembly of Pennsylvania to conduct a study because of concerns that insufficient capacity in its behavioral health system was affecting the level of care and appropriateness of treatment received by patients. The report, issued in July 2020, included fourteen recommendations to address the finding that the behavioral health system in Pennsylvania was underfunded and, in many areas, fragmented to the detriment of individuals in need of behavioral health services.¹⁵ Similarly, in Oregon the Governor’s Behavioral Health Advisory Council was established by executive order in October 2019 and charged with the development of recommendations aimed at addressing the fragmented behavioral health systems in the state and improving access to effective behavioral health services and supports. In October 2020, the Council issued a report with eighteen recommendations for investing in behavioral health services and programs, the behavioral health workforce, and housing and housing supports.¹⁶

Increased need for behavioral health services during the pandemic. Evidence collected during the pandemic suggests the prevalence of behavioral health conditions has increased. For example, results of CDC Household Pulse surveys conducted from April 2020 through February 2021 found that the percentage of adults reporting symptoms of anxiety or depression averaged 38.1 across 24 separate survey collection periods—ranging from a low of 33.9 in mid-May to a high of 42.6 in mid-November.¹⁷ In comparison, a CDC survey conducted in 2019 using similar questions found that about 11.0 percent of U.S. adults reported experiencing these symptoms from January to June 2019.¹⁸

Recent data also show that overdose deaths and suicide attempts have increased during the pandemic. As we previously reported, federal officials and stakeholder organizations that address behavioral health issues expected increases in substance use, mental health disorders,

¹⁵Joint State Government Commission, *Behavioral Health Care System Capacity in Pennsylvania and its Impact on Hospital Emergency Departments and Patient Health* (Harrisburg, PA: General Assembly of the Commonwealth of Pennsylvania, July 2020). Examples of recommendations in the report included recommendations to: expand crisis intervention services within each county; create a student loan forgiveness program to support the workforce for community behavioral health services in underserved and rural communities; and provide resources to support the expansion of telehealth services for behavioral health.

¹⁶Oregon Health Authority, Health Systems Division, Office of Behavioral Health, *Governor’s Behavioral Health Advisory Council Recommendations* (October 2020). Examples of recommendations in the report include recommendations to create a recruitment and retention incentive fund to increase the number of people from underserved and rural communities in the behavioral health workforce and provide funding for continued operations and study of existing Certified Community Behavioral Health Clinic demonstration sites in the state.

¹⁷There were three data collection phases in the Household Pulse Survey. The first phase included 12 separate surveys conducted from April 23 through July 21, 2020. The second phase included five separate surveys conducted from August 19 through October 26, 2020. The third phase of the survey began on October 28, 2020, and as of February 15, 2021, included seven separate surveys. The Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. It is conducted by the Census Bureau in partnership with five other agencies. The weighted response rates have ranged from 1.3 to 10.3 percent. Measures such as the demographic distribution of the survey respondents compared to benchmarks will be produced for data users to consider in their analysis.

¹⁸See Center for Disease Control and Prevention, National Center for Health Statistics, *Early Release of Selected Mental Health Estimates Based on Data from the January–June 2019 National Health Interview Survey* (Atlanta, GA: May 2020). This estimate is based on responses to two questions about symptoms of anxiety disorder and two questions about symptoms of depressive disorder in the prior 14 days. The percentage of adults include those who reported symptoms that generally occurred more than half the days or nearly every day. This estimate was published prior to final data editing and final weighting to provide benchmarks for recent mental health estimates derived from the U.S. Census Bureau’s Household Pulse Survey.

and suicide ideation; data collected during the pandemic corroborate these concerns. For example:

- In September 2020, SAMHSA reported opioid deaths in some areas of the country were as much as 25 to 50 percent higher during the pandemic than the comparison time period in 2019.¹⁹
- In August 2020, CDC published the results of other surveys conducted during late June 2020 related to mental health, substance use, and suicidal ideation during the COVID-19 pandemic.²⁰ Overall, about 41 percent of 5,412 respondents who completed surveys reported symptoms of at least one adverse behavioral health condition, including about 26 percent of respondents who reported trauma- and stressor-related disorder symptoms related to COVID-19.²¹
- An analysis of CDC data published in February 2021 found that the share of emergency department visits for suicide attempts and drug overdoses were 26 and 36 percent higher, respectively, for the period of mid-March through mid-October 2020 compared to the same time period in 2019.²²

In addition, as we previously reported, data provided by SAMHSA indicated that call and text volume to its Disaster Distress Helpline increased considerably during the pandemic as compared to 2019.²³ Specifically, the data showed that between March and August 2020, call volume peaked at 9,965 calls in April 2020—an 890 percent increase over April 2019—and then tapered off in the following months to 3,778 calls in August 2020—a 340 percent increase from August 2019. Text volume increased by even greater percentages, also peaking in April 2020. Additionally, an August 2020 survey by NCBH found that 52 percent of 343 provider member organizations surveyed reported demand for their services increasing in the 3 months before the

¹⁹See Elinore McCance-Katz, *The National Survey on Drug Use and Health: 2019*, (Substance Abuse and Mental Health Administration, September 2020), accessed October 9, 2020, <https://www.samhsa.gov/data/report/dr-elinore-f-mccance-katz-webcast-slides-national-2019>.

Additionally, data from the Overdose Detection Mapping Application Program—a surveillance system that provides near real-time suspected overdose data nationally—showed that, between March and May 2020, over 61 percent of participating counties experienced an increase in overdose reports, with an 18 percent increase in suspected overdose reports when comparing the weeks prior to and following the commencement of state-mandated stay-at-home orders. The Washington/Baltimore High Intensity Drug Trafficking Area, housed within the University of Baltimore Center for Drug Policy and Enforcement, develops and maintains the Overdose Detection Mapping Application Program.

²⁰See M. É. Czeisler, R. I. Lane, E. Petrosky, et al., “Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic United States, June 24–30, 2020,” *Morbidity and Mortality Weekly Report*, vol. 69, no. 32 (2020): p. 1049-1057.

²¹Disorders classified as trauma- and stressor-related disorder in the *Diagnostic and Statistical Manual of Mental Disorders* include post-traumatic stress disorder, acute stress disorder, and adjustment disorders, among others.

²²See K. M. Holland, et al., *Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic*, (JAMA Network, JAMA Psychiatry, February 3, 2021), accessed February 22, 2021, <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2775991>.

²³See [GAO-21-191](#). SAMHSA’s Disaster Distress Helpline provides crisis counseling and support to people experiencing emotional distress related to natural or human-caused disasters. The Disaster Distress Helpline is staffed by trained counselors from a network of crisis call centers located across the United States.

survey.²⁴ New survey data collected by NCBH in February 2021 found that this demand had increased to 67 percent of 332 member organizations surveyed.

Decreased access to behavioral health services during the pandemic. We previously reported that access to behavioral health treatment services was expected to worsen as a result of the COVID-19 pandemic. SAMHSA cited contributing factors, such as layoffs of behavioral health staff and both the loss of providers without the financial reserves to survive long-term, and those unable to generate sufficient revenue to continue to operate.²⁵

Additionally, NCBH's February 2021 survey found that its members reduced staff and decreased services during the COVID-19 pandemic. For example:

- 27 percent of member organizations reported laying off employees;
- 45 percent reported closing some programs;
- 23 percent furloughed employees;
- 35 percent decreased the hours for staff; and
- 68 percent reported having to cancel, reschedule, or turn away patients in the last 3 months.²⁶

The provider groups we interviewed highlighted various stressors associated with the pandemic affecting access to behavioral health services, such as a reduction in outpatient services, limited capacity for inpatient services, and a lack of available resources, particularly for patients requiring in-person services. For example, Virginia Hospital & Healthcare Association officials told us that hospitals have had to block rooms to facilitate social distancing requirements among inpatients, reducing the total number of beds available. Additionally, Texas Hospital Association officials told us that, early in the pandemic some providers closed to new admissions, which reduced patient access to care. These officials also noted that such factors, combined with the increase in demand for behavioral health services, have further exacerbated a mismatch between need for and availability of these services. Of note, however, is that most stakeholders reported a positive effect of the reaction to the pandemic was the increased use of and payment for telehealth, noting it improved access to behavioral health services for some patients not requiring in person services and resulted in fewer missed appointments.

²⁴See National Council for Behavioral Health, *Member Survey: National Council for Behavioral Health Polling Presentation* (September 2020), accessed October 15, 2020, https://www.thenationalcouncil.org/wp-content/uploads/2020/09/NCBH_Member_Survey_Sept_2020_CTD2.pdf.

²⁵See [GAO-21-191](#). As a result of the COVID-19 pandemic, behavioral health care providers, like other health care providers, may have experienced financial losses and changes in operating expenses due to factors such as decreased revenues from cancellations of in-person visits, limitations in services due to social distancing requirements, and increased expenses, such as for purchasing personal protective equipment.

²⁶See National Council for Behavioral Health, *Member Survey: National Council for Behavioral Health Polling Presentation* (February 2021), accessed March 6, 2021, <https://www.thenationalcouncil.org/wp-content/uploads/2021/03/NCBH-Member-Survey-Feb-2021.pdf>

Stakeholders Provided Examples of Concerns about Denials or Delays in Payments for Behavioral Health Services, but Identified Limited Data to Assess Extent of Issues

Stakeholders Provided Anecdotal Examples of Concerns about Denials or Delays in Payments for Behavioral Health Services That Pre-Dated the COVID-19 Pandemic

Most stakeholder groups representing providers offered anecdotal examples of problems with payments for behavioral health services—including issues related to delays and denials of claims—that pre-dated the COVID-19 pandemic. For example, officials from the Virginia Hospital & Healthcare Association told us that they heard from some of its members that they were experiencing more delays or denials for inpatient claims for individuals with combined physical and behavioral diagnoses. Similarly, NCBH officials told us that, according to its members, it often takes significantly longer for claims to be processed for intensive or residential behavioral health treatment compared to similar medical/surgical treatment, such as intensive physical therapy services. Officials from the Texas Hospital Association reported its members have complained that some payments for behavioral health emergencies (such as attempted suicide) leading to hospital admissions have been denied and delayed because of pre-approval requirements. They also noted that hospitals in Texas are generally aware they may receive little to no payment for certain behavioral health services that they know will not be approved for payment (or for full payment), but that the hospitals deem are more therapeutically efficient for the patient than other services.

Additionally, most provider groups we interviewed raised issues with claims payment for behavioral health services under Medicaid more frequently than issues with other payers. For example, representatives from a hospital system in Oregon noted concerns that behavioral health service claims for certain hospital inpatient stays for Medicaid patients that involved both medical/surgical and behavioral health services were routinely denied. NCBH officials noted it is common to experience longer delay times in claims payment under Medicaid managed care plans compared to state-administered Medicaid benefits due to differing standards on what constitutes an acceptable claim. Officials from NCBH and the Pennsylvania Rehabilitation and Community Providers Association also noted that their members had raised complaints about payment for behavioral health services under Medicare because of restrictions on the types of licensed providers approved for payment.

Most stakeholders either told us payments were generally not affected by COVID-19 or it was too early to tell, apart from certain state-specific situations. For example, officials from the Texas Hospital Association told us one of the state's largest Medicaid managed care organizations attempted to roll-out a new payment policy twice during the pandemic that would shift its utilization review process from prior authorization to retrospective review.²⁷ Officials noted that although the policy was likely intended to reduce the administrative burden of prior authorizations and concurrent reviews, it created additional risks and other burdens for hospitals and providers. Officials from the Hospital and Healthsystem Association of Pennsylvania noted concerns about payment denials and delays had decreased during the pandemic, likely as a result of a state policy change implemented in response to the pandemic and requiring an advanced payment model for Medicaid managed care organizations.

²⁷Utilization review is a process health plans use to reduce costs and improve the quality of care by requiring certain services to be approved as medically necessary. Prior authorization occurs before a treatment is received. Retrospective review occurs after a treatment has been administered to determine whether it was appropriate.

Stakeholders Identified Limited Data to Assess the Extent of Issues with the Payment of Claims for Behavioral Health Services

Most stakeholders interviewed during the course of this review told us that, other than anecdotal information collected from members, they were not aware of published data on claims denials or delays that could confirm their concerns. In addition, data from the reports identified during the course of our stakeholder interviews either did not support their concerns or were inconclusive. For example, a 2018 report examining mental health parity in the state of Texas found that the rate of complaints associated with behavioral health services was notably lower than for medical/surgical claims—about 30 per one million behavioral health claims, compared to about 320 per one million claims for medical/surgical services. This report also found that the rate of claims denials did not vary significantly between medical/surgical and behavioral health services—21.7 percent and 21.8 percent, respectively.²⁸ Additionally, an analysis of 2017, 2018, and 2019 claims data collected by the Virginia State Corporation Commission’s Bureau of Insurance found that the rates of claims denials for medical/surgical services compared to behavioral health services were mixed depending on the service provided.²⁹ For example:

- Denials of claims for outpatient office visits were about the same for medical/surgical visits (5.3 percent) as they were for behavioral health visits (5.4 percent).
- Denials of claims for emergency services were higher for medical/surgical services (8.1 percent) than they were for behavioral health services (6.0 percent).
- Denials of claims for inpatient services were lower for medical/surgical services (10.1 percent) than they were for behavioral health services (13.7 percent).

Further, the data showed that, after appeals, a greater percentage of denials were upheld for behavioral health services as compared to denials for medical/surgical services. Virginia officials told us the amount of data for behavioral health services was smaller than that for medical/surgical services, and thus suggested caution in drawing comparisons based on the relatively small number of behavioral health claims. Finally, they noted the data reflect claims from only the individual and small group insurance markets, which are a small share of the total market for health care coverage in the state.

Limited Evidence on Denials or Delays of Claims Could Reflect Previous GAO Findings that Consumers May Be Unaware of or Not Understand Mental Health Parity Requirements

The lack of available data confirming stakeholders’ concerns could be related to potential challenges that consumers and providers face in identifying and reporting mental health parity violations. For example, officials from the Pennsylvania Insurance Department told us they routinely identify issues in mental health coverage (e.g., potentially problematic market practices), which they said is inconsistent with the low number of consumer complaints they receive. These officials told us they are working to develop educational materials for providers to assist them in identifying potential mental health parity violations. Further, claims denials and delays are an important indicator of mental health coverage but reflect only the outcomes of

²⁸See Texas Department of Insurance, *Study of Mental Health Parity to Better Understand Consumer Experiences with Accessing Care* (August 2018).

²⁹See Virginia State Corporation Commission’s Bureau of Insurance, *Claims, Complaints, Appeals—Mental Health & Substance Use Disorder Benefits* (2018 and 2019) and *Claims, Complaints, Appeals—Mental Health & Substance Use Disorder Benefits and Network Adequacy* (2020).

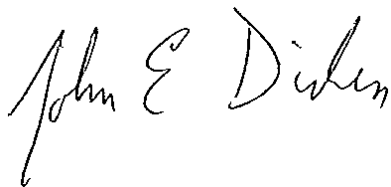
services received and billed and do not account for other challenges consumers may face accessing or receiving mental health services that do not result in a claim.

This is consistent with our findings from a 2019 review of federal and state oversight of parity requirements. In that report, we found that complaints were not a reliable indicator of the extent of noncompliance, because consumers may not know about parity requirements or may have privacy concerns related to submitting a complaint.³⁰ We recommended that DOL and HHS evaluate whether relying on targeted oversight is effective for ensuring compliance with parity requirements and both departments concurred; however, as of March 2021, the agencies had not yet implemented this recommendation.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, the report will be available at no charge on the GAO website at <https://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Other key contributors to this report included Gerardine Brennan (Assistant Director), Nick Bartine (Analyst-in-Charge), Sauravi Chakrabarty, Randi Hall, and Laurie Pachter.

Sincerely yours,

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive, slightly slanted style.

John E. Dicken
Director, Health Care

³⁰See [GAO-20-150](#)

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