



July 31, 2021

The Honorable Frank Pallone, Jr.
Chairman
House Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

The Honorable Patty Murray
Chair
Senate Committee on Health, Education, Labor, and Pensions
United States Senate
Washington, DC 20510

Submitted electronically to Saha Khaterzai, House Committee on Energy and Commerce at publicoption@mail.house.gov and Colin Goldfinch, Senate Committee on Health, Education, Labor, and Pensions at publicoption@help.senate.gov

Dear Representative Pallone and Senator Murray:

On behalf of leading mental health organizations advocating for people with mental health and substance use conditions (The Kennedy Forum, Mental Health America (MHA), The Eating Disorders Coalition, and Well Being Trust), we are pleased to respond to your request for information on design considerations for legislation to develop a public health insurance option that will lower the cost of health care for American families and expand coverage. Our core belief is that all people with mental health conditions and substance use disorders deserve accessible, timely, affordable and comprehensive health care. This belief guides our assessment of any work to reform, change, or improve our nation's health insurance system. We strongly urge that any public option program developed and implemented demonstrate consistency with this belief by including comprehensive mental health and substance use disorder benefits that are subject to the Mental Health Parity and Addiction Equity Act (MHPAEA). Below, we identify some key considerations which we hope you will keep in mind as you develop a public option. These considerations are primarily focused on Question 4, "How should the public option's benefit package be structured?" We are also attaching a consensus document that outlines these recommendations.

Background on Mental Illness

Many people with mental illness are able to access mental health services as a result of having health insurance. However, in 2017, 10.5 percent of adults with a mental illness remained uninsured, which is over 4.7 million people¹. In addition, COVID exacerbated mental health and substance use needs in the general population so it is very important that all coverage include such benefits and require parity and strong networks to ensure accessibility. We believe that expanding access to health insurance is a critical way to ensure that more people can access the mental health services they need and deserve. We share your vision for a system that makes health care simpler and more accessible and affordable for patients and families, and we stand ready to work with Congress and the Administration to work toward this goal.

Public Option Must Provide Comprehensive Mental Health Coverage

Access to coverage and care is essential for people with mental health and/or substance use disorders (MH/SUD) to successfully manage their conditions and get on a path of recovery. At a minimum, a public option must include all coverage protections contained in the Affordable Care Act (ACA), including full MH/SUD coverage under the ACA's Essential Health Benefits.

Before the ACA, comprehensive health insurance was inaccessible for millions of people in the U.S., including many people with MH/SUDs. Health insurers could offer health plans that did not cover mental health services, as well as deny, cancel, or charge more for coverage for people with conditions like mental illness. Medicaid, the public health insurance safety net, was limited to certain categories of low-income individuals and varied across the states. This meant that many people with mental illness were not eligible for public health insurance, could not afford private health insurance, could not find health insurance that included mental health coverage or were denied health insurance due to their mental illness. For others, an SSI disability determination became a pathway to Medicare coverage, although as we'll explain in greater detail below, such coverage continues to fall far short for mental health needs.

With the ACA, a variety of coverage expansions and consumer protections significantly improved the quality and affordability of health insurance and ended many discriminatory practices that especially impacted people with MH/SUDs. As a result of the ACA, people with mental health conditions are more likely to have comprehensive health coverage and receive needed mental health services², such as therapy, inpatient treatment, and prescription medications.

For these reasons, we believe it is critical that any benefits package of a federal public option include ACA protections, *at minimum*, to meet the health needs of those with MH/SUDs. This

¹ <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf>

² <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201600182>

includes specifying mental health and substance use coverage as an essential benefit and including specific language ensuring that parity protections apply to the public option coverage.

Public Option Must Close MH/SUD Coverage Gaps Left By ACA

Including all the ACA's protections is essential for strong MH/SUD coverage, but not sufficient. Despite the ACA, significant coverage gaps remain even in Qualified Health Plans (QHPs). For example, many state benchmark plans fail to cover all intermediate MH/SUD levels of care as described in the American Society of Addiction Medicine (ASAM) Criteria or the American Association of Community Psychiatry's (AACP) Level of Care Utilization System (LOCUS). These gaps in the continuum of the care leave some patients without access to the appropriate level of care.

Additionally and importantly, the ACA's EHB do not currently specify coverage for mental health crisis services. Given the disproportionate rate of poor—even tragic—outcomes for people experiencing mental health and substance use crises, we believe a public option must cover behavioral health crisis services, including mobile crisis teams and crisis stabilization services.³ Ensuring a behavioral health response and not a law enforcement response to crisis will further equity and make crisis services more accessible to communities of color.

State benchmarks also do not cover Coordinated Specialty Care (CSC), which has great demonstrated efficacy from the National Institute of Mental Health's Recovery After an Initial Schizophrenia Episode (RAISE) study. That commercial plans do not cover CSC, which can prevent deterioration associated with untreated psychosis and, often, lifelong disability in many ways demonstrates significant failures in current federal coverage rules. These coverage gaps must not be allowed to continue in a public option.

Public Option Should NOT Duplicate Medicare's Poor MH/SUD Coverage

Medicare's benefit package for MH/SUD is far inferior the benefits required by the ACA. Thus, Medicare should not be used as a model for a public option unless all its MH/SUD coverage deficiencies are fixed. In fact, Medicare is the only major benefit program that is outside the scope of MHPAEA, meaning that discriminatory coverage for MH/SUD treatment within Medicare is legal. For example, Medicare covers medical nutrition therapy (MNT) for diabetes and renal disease, but does not cover MNT for eating disorders, which would be a MHPAEA violation under other benefit programs. Medicare also has a 190-Day lifetime limit on Inpatient Psychiatric Hospital Services. No other medical condition has this limitation, which arbitrarily cuts off necessary treatment for individuals with serious mental illness.

³ For an example of a strong bill that would add behavioral health crisis coverage to EHB, Medicaid, and Medicare, see S. 1902, the Behavioral Health Crisis Services Expansion Act.

In addition, Medicare coverage is limited largely to acute care services and excludes a range of post-acute services and evidence-based mental health services such as intensive case management, peer support services, and psychosocial rehabilitation. There are also limitations on which mental health providers can participate in Medicare and limits on substance use disorder treatment. We find these limitations in Medicare unacceptable. We are concerned that expanding eligibility for Medicare in a public option would result in discriminatory and inequitable coverage and perpetuate health disparities for millions of people who experience MH/SUDs.

It is particularly important that the public option include peer support services. This service has long been covered in Medicaid but has not been covered in Medicare fee for service or private insurance. Medicare Advantage Plans are permitted to cover peer support only in the limited context of non-opioid pain management and it is not a required service. Given the mental health and substance use needs post-COVID and the acute shortages in the behavioral health workforce, peer support is a critical way to quickly expand access and ensure behavioral health workers who reflect the communities they serve. Expanding this workforce of people with psychiatric and substance use disabilities would further equity and provide services that people with these conditions find helpful and effective in meeting their needs.

Public Option Should Have Strong Rules on Medical Necessity Determinations

Individuals needing MH/SUD treatment are often denied critical services simply by flawed determinations by payers that the care they need is “not medically necessary.” Any public option should incorporate key lessons from the landmark federal case *Wit v. United Behavioral Health*, in which the nation’s largest insurer was found to use flawed medical necessity criteria that were inconsistent with generally accepted standards of MH/SUD care. Congress must put in place strong requirements that medical necessity criteria and determinations be consistent with generally accepted standards of MH/SUD care. Congress must also not allow flawed medical necessity definitions and give patients civil enforcement rights. *Depending on the structure of the public option, all rules that apply to the public option program must also apply to any administrator operating plan(s).*

Public Option Must Be Affordable

In order to ensure that more people can receive necessary mental health services, any public option program must be affordable. In 2018, more than 6 million people with serious mental illness had an unmet need for mental health services in the past year⁴ and that nearly 9 in 10 of those with a substance use disorder (SUD) did not receive needed treatment⁵. We also know

⁴ Substance Abuse and Mental Health Services Administration, “Mental Health and Substance Use Disorders,” Available at: <https://www.samhsa.gov/findhelp/disorders>.

⁵ Substance Abuse and Mental Health Services Administration. “Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health,” Available at: <https://www.samhsa.gov/data/>.

that affordability continues to be a pressing concern for the uninsured⁶. These needs have only increased in light of the COVID-19 global pandemic, which has exacerbated the demand for mental health services for children and adults. For these reasons, offering an affordable public option that will last beyond the public health emergency is essential to increasing access to mental health care.

Affordability of coverage should take into account both premium costs and out-of-pocket expenses. It is not adequate to simply ensure that premiums are affordable. Deductibles and other cost-sharing must also be affordable. Premiums and out-of-pocket costs should be nominal or non-existent for low-income populations. Deductibles and out-of-pocket caps should also be limited based on household income to ensure the public option is not catastrophic-only coverage. Enrollees in a public option should be eligible for premium and cost-sharing assistance at levels at least as generous as that available to marketplace enrollees under the ACA and ARP. We also urge the Committees to pursue cost-control mechanisms other than utilization management. Utilization management disproportionately impacts people with disabilities and chronic conditions who frequently need high-cost high-intensity care and do not have lower-cost alternatives. Moreover, some policies promoted as cost-saving strategies that restrict access to medications can cause negative outcomes⁷, sometimes leading to emergency department visits, hospitalizations, homelessness or criminal justice involvement. Finally, Congress should ensure that the public option plan does not impose a pricing structure that relies on Quality Adjusted Life Years (QALYs) or any criteria that places lower value on extended life expectancy based on age or disability.

Public Option Must Offer Robust Mental Health Provider Networks

A primary goal of a public option must be to not only increase the number of people with quality, affordable health coverage, but also ensure that people have access to the services and providers that they need.

In order for people with mental illness to have access to mental health services, the public option must ensure provider networks that include providers in sufficient numbers and types to meet the diverse needs of enrollees, and to ensure that all benefits and services, including MH/SUD services, are accessible without undue delay. Specifically, any public option benefit plan must require a robust mental health provider network, both in quantity large enough to serve the public, as well as diversity of providers to meet the full spectrum of needs for people with MH/SUD conditions. This should include a broad range of providers like psychologists, psychiatrists, therapists, social workers, case managers, peer support specialists, and other MH/SUD professionals. Provider networks should also reflect the diversity of its enrollees in

⁶ https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage?utm_source=Sailthru&utm_medium=email&utm_campaign=VoxCare%206/17/21&utm_term=VoxCare

⁷ <https://ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.5.601>

terms of race, ethnicity, gender identity, and sexual orientation, and must provide culturally- and linguistically-competent care.

With network adequacy for QHPs, states set the rules, which often have large variability and insufficient standards for MH and SUD providers. The federal government should require stronger network adequacy rules for all QHPs, including the public option. Network adequacy standards should include quantitative requirements for timely and geographic access to services for MH and SUD, separately and at a minimum, should incorporate time and distance standards as well as wait times. If these requirements are not met for an individual enrollee, they should be allowed to access out-of-network services at in-network cost-sharing (with protections against balanced billing from out-of-network providers). Without the ability to access care at no additional costs when provider networks are inadequate, network adequacy requirements are too often hollow.

Public Option Must Ensure Equal MH/SUD Provider Rates

Unfortunately, there exists a serious shortage of mental health professionals across almost all specialties, further exacerbated by the COVID-19 pandemic that is particularly acute in rural areas and communities of color. Because of this shortage, many children, adolescents, and adults continue to go without needed, potentially life-saving, equitable mental health care. As any federal public option looks to lower the cost of health care for American families and dramatically expand coverage, ensuring payment levels that are adequate to attract and retain an appropriately-sized and diverse mental health workforce is critical to its success.

Any public option must require that behavioral health providers and services are paid at rates that support quality accessible care. Medicaid rates are typically too low to appropriately support effective services, and Medicare has no rates for the many behavioral health services and providers that they do not cover. A public option should require that rates, including out-of-network rates, ensure parity between behavioral health and other health care providers and reflect costs of care. The Secretary could also develop rates, including out-of-network rates, that ensure parity between behavioral health and other health care providers and that reflect costs of care.

Public Option Must Advance Care Integration

Currently, mental health is often not integrated into primary care, where many common conditions can be successfully treated. Such integration is vital given the shortages of specialists and the lag in wait times. Primary care should be defined to include mental health care and cost sharing should not be required for that care when provided in primary care. The public option must reimburse for evidence-based models that integrate mental health into primary care with rates that fully cover startup and ongoing costs for practices. Financial incentives for mental health clinicians integrated into the practice and utilizing evidence based models for integration; telehealth consultative model well reimbursed; technical assistance grants for

integrated care; pathways to integration with payment for certain process and outcomes similar to the work in Arizona, Colorado and other states with process and outcomes and significant funding of mental health clinicians and EHR capacity. Attachment A to this letter is a recent report by the Bipartisan Policy Center Task Force on Integrated Care.

Public Option Must Measure MH/SUD Outcomes

Any outcome measures must sufficiently incentivize high-quality integrated care. In the past, measures have been predominately general process measures that do not adequately measure clinical outcomes associated with integrating care. Congress should require the development of a transparent system to measure outcomes, including patient experience and clinical outcomes. Any rating system, like the Medicare star ratings, should incentivize effective integration of mental health care in primary care.

Public Option Must Ensure Full Access to Telehealth

Given the acute shortages in the mental health workforce, telehealth has been particularly important in meeting the needs of individuals with mental health and substance use conditions. Clinicians and individuals need to flexibility to decide on the best modality for treatment based on clinical needs and individual barriers, such as transportation and childcare. The public option should allow telehealth without mandatory in person requirements. The decision of whether to require in person care should be made by the mental health professional and individual collaboratively and not by an arbitrary rule. Moreover, audio only care should be permitted if individuals prefer that modality. Finally, providers should be compensated at parity with office-based care so there is no disincentive to provide care by telehealth.

Conclusion

Thank you for the opportunity to provide comments on this important issue. We hope you will use these principles to ensure that the needs of people with mental health and substance use disorder conditions are fully represented in a federal public option. We look forward to working with you to achieve a goal of universal coverage and making health care simpler, more affordable—and more accessible and effective, for people with mental health and substance use conditions and their families. If you have any questions, please do not hesitate to contact Dr. Benjamin Miller, president, Well Being Trust at ben@wellbeingtrust.org .

Sincerely,
The Kennedy Forum
Mental Health America
The Eating Disorders Coalition
Inseparable
Well Being Trust

**Exhibit A –
Key Sample Language for Public Option Statutory Text**

Recommended Language	Rationale
<p><u>“COVERAGE DETERMINATIONS.—The health plan and any third-party administrator of a public option plan shall cover a service or product for the purpose of preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is—</u></p> <p><u>‘(1) In accordance with the generally accepted standards of care;</u></p> <p><u>‘(2) Clinically appropriate in terms of type, frequency, extent, site, and duration; and</u></p> <p><u>‘(3) Not primarily for the economic benefit of the health plan or for the convenience of the patient, treating physician, or other health care provider.</u></p>	<ul style="list-style-type: none"> • It is critical that there be a standardized definition of medical necessity that do not serve patients’ best interests. • This definition is based off of the American Medical Association and American Psychiatric Association-endorsed definition. • The reference to “generally accepted standards of care” is a key concept from the landmark findings of the federal court in <i>Wit v. United Behavioral Health</i>.
<p><u>“GENERALLY ACCEPTED STANDARDS.—For purposes of subsection [X], “generally accepted standards of care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Sources reflecting generally accepted standards of care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.</u></p>	<ul style="list-style-type: none"> • This explicit definition of “generally accepted standards of care” uses a common-sense definition that is consistent with what the federal court used in <i>Wit</i>.
<p><u>“CIVIL ENFORCEMENT.— Participants and beneficiaries to a public option plan, or their designees, shall be entitled to the same rights provided to participants and beneficiaries in section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1132), including the right to bring a civil action against the health plan and/or any third-party administrator of a</u></p>	<ul style="list-style-type: none"> • ERISA provides for meaningful remedies that the PHSA does not. Therefore, Congress should mirror the rights under ERISA. Americans receiving coverage under the public option plan should not have fewer rights than those in ERISA plans.

<p><u>public option plan. Further, any cause of action brought under this Section shall not be subject to mandatory arbitration, and any coverage decisions by the plan and/or third-party administrator will be subject to <i>de novo</i> review in court.</u></p>	<ul style="list-style-type: none"> • Without such a right, landmark cases like <i>Wit</i> would never have been possible. • Binding mandatory binding arbitration should not be allowed nor should heightened review standards that hinder overturning wrongful denials.
<p>“REIMBURSEMENT RATES. “(a) MEDICARE RATES.— “(1) IN GENERAL.—Except as provided in paragraph (2) and subsections (b) and (c) and subject to subsection (d), the Secretary shall reimburse health care providers furnishing items and services under the health plan at rates determined for equivalent items and services under the original Medicare fee for-service program under parts A and B of title XVIII. <u>With respect to mental health and substance use services, the Secretary shall reimburse health care providers at Medicare adjusted to comply with MHPAEA.</u></p>	<ul style="list-style-type: none"> • Medicare rates are unfortunately biased against mental health. • To avoid baking in discriminatory Medicare rates, the Secretary should be empowered to change reimbursement rates to comply with MHPAEA.
<p>“(2) AUTHORITY TO INCREASE PAYMENTS RATES IN RURAL AREAS <u>AND IN MENTAL HEALTH CARE PROFESSIONAL SHORTAGE AREAS.</u>—If the Secretary determines appropriate, the Secretary may increase the reimbursements rates described in paragraph (1) by up to 50 percent for items and services furnished in rural areas (as defined in section 1886(d)(2)(D)) <u>and for mental health and substance use items and services furnished in mental health care health professional shortage areas as designed by the Secretary pursuant to 42 U.S. Code § 254e.</u></p>	<ul style="list-style-type: none"> • Increasing payment rates in only rural areas leaves out other underserved areas. • Given the low reimbursement rates for mental health, increasing rates in Mental Health Professional Shortage Areas would be very important to increasing access.