AMERICAN PSYCHOLOGICAL ASSOCIATION

July 30, 2021

The Honorable Frank Pallone, Jr.
Chair
House Committee on Energy and Commerce
2107 Rayburn House Office Building
Washington, DC 20515

The Honorable Patty Murray
Chair
Senate HELP Committee
154 Russell Senate Office Building
Washington, DC 20510

Dear Chair Pallone and Chair Murray,

On behalf of the American Psychological Association (APA)[1], I would like to thank you for your recent letter requesting stakeholder input on the design of a "public option" to compete with private insurance plans. As you know, Congress' enactment of the Patient Protection and Affordable Care Act (ACA) over a decade ago led to a historic expansion in health care coverage. As of February 2021, 31 million people now have coverage thanks to the ACA, including 11.3 million enrolled in plans through the Exchange and 14.8 million enrolled in Medicaid through the ACA's expanded eligibility criteria.[2] However, millions remain uninsured,[3] particularly in the 12 states that refused to expand Medicaid eligibility. While the ACA improved access to health insurance for all Americans to some degree, Black and Latino adults continue to represent a disproportionate share of those who remain uninsured.[4] In designing this public option, we urge you to consider the following recommendations.

Eligibility and Benefits

Your public option proposal represents an opportunity to close persistent gaps in coverage, especially in communities or geographic areas where competition among private insurance plans

[1] APA is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 122,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science.

[2] HHS Assistant Secretary for Planning and Evaluation Office of Health Policy (June 5, 2021). *Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates*, Issue Brief HP-2021-13. Retrieved July 19, 2021, from https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//200776/ASPE%20Issue%20Brief-ACA-Related%20Coverage%20by%20State.pdf.

[3] Garfield, R., Orgera, K., et. al. (January 21, 2021). *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*. Retrieved July 19, 2021, from https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

[4] Chaudry, A., Jackson, A., et. al. (August 21, 2019). *Did the Affordable Care Act Reduce Racial and Ethnic Disparities in Health Insurance Coverage?* Retrieved July 19, 2021, from https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage.

remains low, many continue to find private insurance unaffordable, and Medicaid or other public programs are unavailable. To remedy these affordability issues and persistent disparities in access to coverage, eligibility for the public option should include, at minimum, all U.S. citizens, nationals, and lawful permanent residents currently eligible to enroll in insurance through the ACA exchanges. Likewise, the package of services offered by the public option should include, at minimum, those services defined as "Essential Health Benefits" under the ACA.[5] While states should have flexibility to offer additional benefits or test different evidence-based payment or treatment models, in no state should a patient enrolled in the public option be denied coverage for mental and behavioral health services or substance use treatment simply because they reside in a state where those services are not covered through the public option.

Additionally, the public option must include coverage of mental and behavioral health and substance use services furnished by telehealth, including audio-only telehealth. During the COVID-19 pandemic, expanded access to these services via telehealth addressed health equity by facilitating an unprecedented expansion of access to mental health treatment, particularly amongst rural and underserved communities. Audio-only telehealth has proven an especially critical benefit for individuals living in areas lacking broadband Internet access or who lack the technology to facilitate an audio-video telehealth appointment.

Importantly, we urge you not to use Medicare as a template for designing the benefits package offered by this public option. The Medicare system discriminates against mental and behavioral health services by imposing coverage limitations that uniquely apply to these services, and Medicare and Medicare Advantage plans are also exempt from federal parity mandates. Medicare also imposes an arbitrary 190-day lifetime limit on coverage of inpatient psychiatric hospital services, a limitation that applies to no other inpatient service. As a result, Medicare enrollees with serious mental illness are cut off from coverage regardless of the severity of their symptoms. Medicare also does not cover intensive outpatient services for mental health and substance use treatment, nor does it cover evidence-based team interventions for treatment of mental health or substance use needs, such as Coordinated Specialty Care for treatment of early psychosis, Assertive Community Treatment (ACT) teams for people experiencing a crisis, and medical nutrition therapy for treatment of eating disorders. We ask that this public option avoid following Medicare's example and place coverage of mental and behavioral health needs on equal footing with medical services.

Parity Compliance

We also see the public option as a chance for the federal government to lead the way on compliance with federal parity law. Despite the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) over a decade ago, many providers continue to experience inequitable coverage for mental and behavioral health treatment—such as narrower provider networks or lower reimbursement rates—than for comparable medical services. To ensure that patients retain the

[5] 42 U.S.C. § 18022(b).

choice between telehealth and in-person services, we also ask that the public option not just meet, but exceed, its existing parity obligations and cover mental, behavioral, and substance use services furnished via telehealth on the same terms and at the same rates as their in-person counterparts.

Integrated Care

The public option may also look towards integrating primary care and mental health services as a means of expanding access to mental and behavioral health care, improving patient outcomes and satisfaction with care, and reducing overall treatment costs. However, while integrated care models do have the potential to achieve these goals, provider adoption of these models requires significant changes to providers' physical offices, information technology systems, management procedures, health records and data tracking practices, and provider education and training. Given these challenges, as well as differences in patient populations and the goals of the integration effort, there is no "one size fits all" approach to integrated primary care. There are several evidence-based models of integrated care that are more effective in certain areas or patient populations than others, and approaches to integration should be responsive to the specific needs and environment of the community. We ask that the public option adopt a flexible approach towards covering an array of evidence-based forms of integrated care and avoid a one-size-fits-all approach.

Reimbursement

The success or failure of this public option rests in large part on its ability to attract enough providers capable of providing adequate access to care for enrollees. APA fundamentally believes that any public option should include reasonable standards for provider participation, and that provider participation in the public option cannot limit their ability to participate in other plans. Additionally, current public insurance programs offer substandard rates compared to those offered in private plans. For example, private insurance plans reimburse for physician services an average of nearly 50% higher than Medicare[6], while Medicaid pays out an estimated 72% of what Medicare does nationally[7] for these services. As a result, while many providers accept a few patients enrolled in Medicare or Medicaid as a form of public service, they often cannot serve a large volume of patients covered by these programs because the rates are insufficient to maintain a sustainable clinical practice.

Because the public option would presumably compete with private plans for providers' clinical time, we suggest that the reimbursement rates offered by the public option must be no lower than either (a) the Medicare benchmark rate, including any applicable geographic price adjustments; or (b) the median rate offered in plans through the ACA exchanges, whichever is higher. APA also

[6] Lopez, E., Neuman, T., et. al. (April 15, 2020). *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*. Retrieved July 19, 2021, from https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/.

[7] Zuckerman, S., Skopec, L., et. al. (February 2021). Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019, *Health Affairs*, 40(2). Retrieved July 19, 2021, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.00611.

recommends consideration of additional incentives—such as student loan forgiveness or bonus payments—to draw providers into accepting patients covered by the public option, particularly for enrollees in rural areas and underserved communities that have long struggled to attract an adequate provider workforce.

Administrative Burdens

Additionally, while APA supports reasonable efforts to combat fraud, waste, and abuse in public health programs, APA's members have long seen how unfettered audit requests can unnecessarily limit providers' ability to participate in these programs. Psychologists spend countless hours responding to exhaustive requests for information from an array of insurers, often with an implicit or explicit threat of recoupment of submitted and reimbursed claims. Many of these requests have nothing to do with an actual assertion of fraud, waste, or abuse but rather are about broader inquiries concerning billing patterns. For example, in 2015 many psychologists received letters from a contractor of Anthem Blue Cross Blue Shield concerning a broad utilization review of the CPT code 90837 (psychotherapy, 60 minutes with patient and/or family member). While fortunately APA was able to obtain some clarification from Anthem on the scope and nature of this request, our clinicians nonetheless spent countless hours and resources complying with this single request, unnecessarily diverting time and resources away from interactions with patients.

Even within the nationwide Medicare program, different Medicare Administrative Contractors (MACs) utilize different standards for recordkeeping, creating confusion as to the standards with which providers are expected to comply. To balance the need for program integrity with the need for efficiency, APA recommends a "hold harmless" or "safe harbor" provision that alleviates the fear of recoupment under an audit not tied to an actual fraud, waste or abuse investigation. Alternatively, your public option proposal can include a 6-month "statute of limitations" on audits so providers have the security of knowing whether their claims will be audited within a reasonable timeframe after they are submitted.

Innovation

APA also sees your bill a means of guiding the future of mental health treatment, as coverage protocols have not kept pace with recent advances in technology. For example, a growing body of research supports the efficacy of virtual reality (VR) in psychological treatment, such as exposure therapy for treatment of Post-Traumatic Stress Disorder. The Veterans Administration leads the way in early adoption of VR, However, most people lack access to equipment necessary for these types of VR treatments. As a result, a public option should not limit itself to narrow definitions of which specific forms of equipment constitute appropriate treatment delivery.

With rates of substance use—including opioids and methamphetamine—continuing to climb during the COVID-19 pandemic, this public option also can be utilized to overcome barriers on coverage of innovative forms of substance use treatment. For example, contingency management (CM) is a behavioral treatment that provides reinforcement for targeted behaviors, such as

abstinence from substance use, and its effectiveness is supported by decades of research.[8] Both the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration recognize CM as effective, and it is used within the Veterans Health Administration.[9] Unfortunately, only a small minority of patients receive CM services, due primarily to federal restrictions on the use of financial incentives related to treatment which affects referrals to federal health care programs.[10]

Thank you again for the opportunity to weigh in on this important effort to ensure the broadest possible access to mental and behavioral health services. APA stands ready to assist your offices in crafting this bill. Please contact Andrew Strickland, J.D. at astrickland@apa.org if our association can serve as a resource.

Sincerely,

Katherine B. McGuire
Chief Advocacy Officer

[8] Roll, J. M., Higgins, S. T., & Badger, G. J. (1996). An experimental comparison of three different schedules of reinforcement of drug abstinence using cigarette smoking as an exemplar. *Journal of applied behavior analysis*, *29*(4), 495-505.
[9] Petry, N. M., DePhilippis, D., Rash, C. J., Drapkin, M., & McKay, J. R. (2014). Nationwide dissemination of contingency management: The Veterans Administration initiative. *The American Journal on Addictions*, *23*(3), 205-210.
[10] Office of the Inspector General. (2011, December 12). *Federal Anti-kickback Statute*. U.S. Department of Health and Human Services. Retrieved July 16, 2021, from https://oig.hhs.gov/newsroom/oig-podcasts/federal-anti-kickback-statute/