Commonwealth of Massachusetts
Supreme Judicial Court

MENTAL HEALTH LEGAL ADVISORS COMMITTEE

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Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109

RE: HPC Cost Benchmark for 2021

Dear Commissioners:

This testimony expands upon the verbal testimony of Mental Health Legal Advisors Committee[1] (MHLAC) at the March 11, 2020 Health Policy Commission (HPC) benchmark hearing.

In light of the Covid-19 pandemic, neither now nor the foreseeable future is the time to rely upon the financial strategies touted in the past – limited networks, deductibles, tiering, and other "demand-side incentives." MHLAC has submitted substantial testimony documenting the counterproductive results of such tools and their damage to health care quality and long-term cost control. Maintaining these faulty cost control schemes in this time of crisis will not only be ineffectual for

[1] MHLAC is an agency under the Massachusetts Supreme Judicial Court that provides representation to low-income persons with psychiatric challenges. MHLAC also provides information and advice to any Commonwealth resident, including the legislature, other agencies and commissions on mental health legal matters. In this role, MHLAC has extensive hands-on experience regarding the barriers people with psychiatric diagnoses have with respect to accessing health care services and obtaining quality care once those services are obtained.

long-term reduction in expenditures, but toxic to the health and well-being of people throughout the Commonwealth.

Limited networks:

Recommendation: Require insurers to cover out-of-network care with single-case agreements, with insurer payment of out-of-network providers at in-network rates and no increased cost-sharing to insureds.

Limited networks reduce access to health care providers; that is the function of limited networks. "Constrained", "reduced", and "restricted" are words frequently used in lieu of "limited". "Inadequate", another word sometimes used in lieu of "limited", is more appropriate, especially in the face of a pandemic.[2]

- **As providers become ill, restricting access to only in-network providers is the equivalent to restricting access to health care.** At a time when government should be and to some extent is attempting to increase access to health care, this is not the time to maintain unnecessary barriers to getting care.

Current insurer practices with respect to coverage of out-of-network care are impediments to access and successful treatment outcomes. Even though limited network plans are arguably required to cover out-of-networks providers if an appropriate in-network provider is not available, the difficulty of obtaining out-of-network coverage is mind-boggling. One example is an insurer who required a patient, whose only mode of transportation was a bicycle, to leave her treating clinician and travel one hour each way to another provider. This made going to appointments a minimum three-hour ordeal and interfered seriously with her limited livelihood. Another example is an insurer who thought it appropriate to require a client with 13 different personalities to switch therapists and begin her treatment anew with an in-network provider who would have to meet each of those personalities to treat her. MHLAC actually had to go to court to correct this egregious denial of out-of-network coverage.

[2] It is important to note that coverage of out-of-network providers should not be limited to the immediate emergency situation. Far after the control of the pandemic, the mental and physical fall-out from the crisis will continue. Continuity of care is and will remain an essential component of producing positive health outcomes.

Consumers do not have the wherewithal to challenge insurer contentions that in-network providers can meet their needs and often forego treatment. Clinicians are better utilized providing treatment rather than battling insurers over the medical necessity of out-of-network coverage.

- **As people lose their jobs, they are forced to change insurers, whose networks vary.** Without insurance coverage for out-of-network providers and the inability to pay out of pocket, people will be forced to abandon treatment with providers who have been fundamental to their health. With respect to mental health, continuity of care and the therapeutic relationship that accompanies it is the single most accurate predictor of successful outcomes. The provision of a transition period to a new provider does not reduce the stress and damage to recovery done by ending such an intimate relationship as the one between a therapist and a patient – even with 30, 60, or 90-days of anticipation.

- **Loss of continuity of care can cause decompensation and disrupt recovery at a time when businesses and Massachusetts will be experiencing financial challenges.** Since insurers only have to pay the in-network rate to out-of-network providers under our recommendation, risking longer and more intensive care does not make economic sense.

***Demand-side incentives*:**

Recommendation: Eliminate tiered co-pays; excessive co-pays for imaging and laboratory tests; deductibles; and elevated co-pays for out-of-network care.

Demand-side incentives financially burden patients, are of questionable efficacy in reducing overall health care costs, and harm quality of care. Patient out-of-pocket expenditures have grown far more than expenditures by employers and insurers and more than the inflation rate. Loss of income and family illness due to Covid-19 have placed many people in increasingly precarious economic circumstances that are barely resolved by federal and state responses. MHLAC has consistently advised against the use of demand-side incentives to control costs.

Tiering: In addition to problems with tiering noted in prior MHLAC testimony,[3] further reasons to cease basing copays on insurer tiering of providers have arisen. In light of the fact that our health care system is inadequate to meet demand for treatment of both virus-related illness and regular acute and chronic conditions, asking people to choose providers based on tiering is ludicrous, amounting to a veiled means of pilfering the funds of insureds.

Other demand-side incentives – co-pays for imaging and testing; deductibles: Higher patient costs lead to avoidance of appropriate use of care, which ultimately leads to more expensive modalities of treatment.[4] In the face of a highly contagious virus, excessive co-pays for imaging and testing, as well as deductibles, create a public health problem. Even when co-pays are waived for Covid-19-related diagnosis and treatment, deductibles and excessive co-pays remain for the diagnosis and treatment of medical conditions that compromise the immune system and increase susceptibility to the virus.

Person-centered care and alternative and innovative services:

Recommendation: Insurers should be required to promote and fund access to alternative and innovative services, such as meditation, yoga, exercise, and peer support via telehealth. Insurers also should contribute to the costs of insureds to access these services, including paying for or subsidizing telephone and internet charges, fees, and equipment. To the extent that individual providers and small non-profit organizations need assistance in establishing or sustaining the infrastructure to provide these services, payment rates to these providers should reflect those needs.

Person-centered care and innovative services still offer the opportunity to lower health care costs. Unfortunately, insurers rarely cover these services, often

[3] Tiering criteria are not open to public review, are primarily based on cost and not quality, are insufficiently granular to ensure optimal care, and do not account for the individual characteristics of each patient.

[4] The health care system should not increase disease by increasing the financial burdens of consumers. Money, finances, and debt are the most common source of anxiety and are linked to the aggravation of mental health conditions. Financial difficulty drastically reduces recovery rates for common mental health conditions. Financial difficulties also increase demand for health care services. K. Evans, *The link between financial difficulty and mental health problems*, 27 J. Mental Health 487 (2018).

claiming that they are not "evidence-based."[5] Yet offering patients a broad array of options from which to choose increases patient engagement and the potential for recovery, ultimately saving insurers money.

Currently, insurance coverage of and funding for treatments and services that bolster the immune system are particularly needed. For example, there is ample evidence that meditation, yoga, and exercise protect and bolster the immune system.[6] These services can be accessed through web-based sessions and classes.[7,8]

MHLAC also is concerned with the plight of persons in psychiatric hospitals and other group settings,[9] as well as whether persons with disabilities will be unjustly

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[5] As MHLAC has previously testified, public funding for research should be targeted to those services and treatments that are not likely to be otherwise funded because they will not produce large profits for corporations. Practice evidence should be included in determining whether a modality of treatment is "evidence-based."

[6] See, e.g., A. Seiler, C. Fagundes, L. Christian, *The Impact of Everyday Stressors on the Immune System and Health*, https://link.springer.com/chapter/10.1007/978-3-030-16996-1_6#CR3 (Springer 2019) (last accessed 3/27/2020).

> [P]sychological interventions including cognitive behavioral stress management, meditation, and yoga have been demonstrated to improve immune function in diverse populations….Undoubtedly, exercise is a powerful behavioral intervention with the potential to improve immune function and health outcomes in the healthy, the obese, and the elderly, as well as in patients specifically having CVD, diabetes, or cancer.

[7] Older adults, who are at heighted risk of contracting Covid-19, are motivated to exercise if part of a group of people exercising. C. Steltenpohl, *et al.*, *Me Time, or We Time? Age Differences in Motivation for Exercise*, 59 The Gerontologist 709 (2019). Such group membership can be offered through virtual means, whether by uncomplicated telephone conferencing to take attendance and allow members to verbally interact, or through web services.

[8]See, e.g., K. Chemtob, *et al.,* *Using tele-health to enhance motivation, leisure time physical activity, and quality of life in adults with spinal cord injury: A self-determination theory-based pilot randomized control trial*, 43 Psych. Sport & Exercise 243 (2019) (physical activity motivation support can be delivered through a videoconference platform).

[9] Expanding the number of professions that can involuntarily commit individuals to group settings is dangerous and unwarranted. In addition, insurers have an incentive to investigate (1) whether continued residence in group settings is warranted by treatment needs that can not be met on an outpatient basis or by providing patients with an array of alternative options or (2) whether the risk of exposure to Covid-19 and incapacity of inpatient and group settings to enable social distancing and isolation, as well as their

denied access to care based on discriminatory triaging criteria, a topic generally touched upon in our discussions with the HPC in relation to the criteria used to setting the criteria for the value of medications.

Thank you for this opportunity to address how the Commonwealth will address providing quality health care while being cognizant of cost. Please know that our agency is available to assist the HPC at any time.

Sincerely,

Susan Fendell
Senior Attorney

inability to provide care for infected patients, outweighs any benefit of remaining in the group setting. Obviously, discharge should not place a patient in a more dangerous setting. Insurers should assist and provide funds for individual supported housing if that is the best post-treatment plan.