A Policy Proposal for the COVID-19 Mental Health Relief Subsidy

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The Coronavirus pandemic (COVID-19) continues to exacerbate wounds in the United States society. Among the chief concerns are the pressing national mental health crisis, unemployment, and the impacts of the social justice movements in 2020. Arguably, each of the topics mentioned feeds into the mental health crisis, as mental health is impacted by stress and social upheaval. The pandemic has driven up the unemployment rate, putting those at risk for unemployment at higher risk for mental health issues (Ganson et al., 2021). The social justice campaigns in 2020, including Black Lives Matter, are a response to the injustice of racism in the US (Black Lives Matter, n.d.). Apart from events provoking these movements, the Black community is at higher risk for COVID infection and death, increasing their risk for poor mental health due to bereavement (Millet et al., 2020). Beyond social stress and unemployment, the pandemic itself is reason enough for poor mental health. COVID-19 produced health risks, social stress, and isolation resulting in an increase in suicidal ideation and attempts among the population in the US (Amerman et al., 2021). The COVID-19 pandemic brought us a second pandemic, a mental health crisis. Policies have repeatedly devoted their resources to ending the COVID-19 pandemic before addressing the aftershocks. President Biden used his first day in office to install Executive Order 13991, a mask mandate for federal buildings (Exec. Order No. 13,991, 2021, p. 7,045). This policy acted as a first step towards ending the pandemic so the US can heal. This effort is vital as the US has seen increased suicidal ideation and higher mental health risks for disadvantaged children and adolescents (Ammerman et al., 2021, Fegert et al., 2020). However, this effort is not enough to address the mental health crisis that the US is already experiencing. The US needs a radical mental health and healthcare policy to address our mental health emergency, namely a mental health service subsidy for those at the highest risk.

History of Related Policies

Several policies address the COVID-19 pandemic and its impacts, including the mask mandates and stimulus checks. The Centers for Disease Control and Prevention (CDC) have continually recommended non-pharmaceutical measures, including handwashing, mask-wearing, and social distancing, to reduce the transmission of the virus (CDC, 2020). When President Biden took office in January of 2021, he issued a federal mask-mandate, Executive Order 13991, to require masks in federal buildings and encourage mask-wearing across the US (Exec. Order No. 13,991, 2021, p. 7,045). In addition to implementing non-pharmaceutical measures, the US government passed relief packages that sent stimulus checks to citizens under a specific income (Peter G. Peterson Foundation, 2021). The government used the stimulus check policies to directly address the economic distress created by the pandemic, including unemployment and reduced economic circulation (Peter G. Peterson Foundation, 2021). This relief for the financial side of the pandemic came in tandem with the mandates created to end the pandemic, including federal and state-level mask mandates. The priority behind these policies is the need to end the pandemic. There has been a multitude of issues exacerbated by the pandemic, including unemployment, social injustice, and poorer mental health (Ganson et al., 2021; Millet et al., 2020; Turna et al., 2021). The best way to address these issues is to end the pandemic, thus removing one of the main causal agents. Ending the pandemic is the motivating factor behind many pandemic policies, but pandemic policies are not enough to cover mental health issues.

There have also been policies that address mental health accessibility apart from the COVID-19 pandemic, including the Affordable Care Act (ACA), Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). The ACA was signed into legislation in 2010 and made the cost of medical expenses less, including reproductive health, prescriptions, and mental

health services (Compilation of Patient Protection and Affordable Care Act, 2010). The ACA addressed mental health services by requiring insurances to cover those services and substance abuse treatments (Compilation of Patient Protection and Affordable Care Act, 2010). Medicaid also addresses mental health service accessibility, especially for those with low income (Centers for Medicare & Medicaid Services [CMS], n.d.b). Medicaid provides insurance at a lower cost and covers behavioral health and substance abuse services (CMS, n.d.b). These services are protected under the Mental Health Parity and Addiction Equity Act (MHPAEA), meaning the quality or cap on services is no different for Medicaid users (CMS, n.d.c). CHIP is an insurance program for children in families that do not qualify for Medicaid, but they are still protected under the MHPAEA for substance abuse (CMS, n.d.b). These policies help to alleviate the burden of mental health services, which are exceedingly expensive in some cases, for those with low income since they are a group with a high risk for mental health (CMS, n.d.a). In addition to these policies, the federal government issues state grants for mental health services, meaning that the states gain financial assistance to devote to their mental health services (Karger & Stoesz, 2017). Evidence suggests that these services help to relieve some of the stress in mental health services accessibility, and Medicaid, in particular, has relieved some of the stress due to COVID-19, but they are not enough (Donnelly & Farina, 2021).

Proposed Policy: The COVID Mental Health Relief Subsidy

The COVID Mental Health Relief Subsidy (CMHRS) responds to the mental health crisis the US is facing because of the COVID-19 pandemic. Mental health is affected by many factors, many of which have changed in the COVID-19 pandemic. Unemployment is one of the pressing issues of the pandemic, in tandem with a recession, which creates unrest in the house and drives poor mental health (Raifman et al., 2021). Food insecurity is another factor that has increased

due to the pandemic, in correlation with unemployment (Nagata et al., 2021). In tandem with the social justice upheaval that the US has seen in the past year, these factors have impacted the nation's mental health more than is realized. Stress can produce poor mental health, and the US has seen a steady increase in anxiety and other mental health conditions because of the pandemic (Turna et al., 2021).

The main goals of the subsidy are to address the impact the COVID-19 pandemic has had on mental health in the US and provide relief for those at high risk for poor mental health. The first goal is to address the poor mental health in the US generally. In combination with social stresses like unemployment and social justice, the stress of the pandemic has created an environment that encourages poor mental health. Children and adolescents that may have already had mental health issues have steeped in them in isolation without a chance for much help from professionals (Fegert et al., 2021). In a study done by Hoyt et al. (2021), it was found that college students suffer from poor mental health provoked by COVID-19, especially those who identify as female or transgender and those with minority sexuality identities. General anxiety and suicidal ideation have also increased, as previously discussed, delivering an undeniable prompt for a policy change (Ammerman et al., 2021; Turna et al., 2021). In response to these issues, the COVID mental health relief subsidy seeks to address these issues by providing greater access to mental health services through reduced prices.

Mental health is important for everyone, but the CMHRS is fitting to address the needs of those most at risk, which is the second goal. Those at a higher risk for poor mental health have been impacted by the COVID-19 pandemic, including those with low income (Yang & Xiang, 2021). Lower socioeconomic status and high-poverty neighborhoods felt a strong disparity for mental health because of COVID (Yang & Xiang, 2021). These neighborhoods and individuals

were already living in a disparity because of their social determinants of health including, poor housing and poor access to health care. Beyond the underlying disparity, unemployment and COVID infection and deaths followed disadvantaged groups, including Black, Native American, and Latinx citizens (Couch et al., 2020; Tai et al., 2021). The social determinants impacting COVID risk and unemployment culminate to create a higher risk for poor mental health due to increased stress. Gazmararian et al. (2021) found that mental health outcomes were correlated to low socioeconomic status and racial minorities due to their undue risk in the pandemic. To address the mental health disparity caused by COVID and exacerbated due to the already systemically racist and inequitable US society, the CMHRS seeks to provide healthcare access to the populations who have been hurt for years.

The CMHRS will achieve its goals of addressing the mental health crisis and providing mental healthcare access to those at most risk by providing what is in its name: a subsidy. The CMHRS is built to act much like the affordable care act, Medicaid, CHIP, and state grants combined to provide lower costs for mental health services for those with low income. Medicaid decreased mental health costs for many people, even if there was no increase in mental health service utilization (Golberstein & Gonzales, 2015). Medicaid and CHIP coverage varies by state, but it provides a significant amount of coverage (CMS, n.d.a). The CMHRS is similar in that it covers many expenses, but it differs in that clients do not have to sign up for insurance to be eligible. The CMHRS follows suit to state grants, which allow states to designate funds to community mental health by providing states with funds to devote to mental health services (Karger & Stoesz, 2017). The CMHRS acts as additional coverage for those with low income with or without insurance coverage. In this way, the CMHRS addresses the current mental health crisis by designating money for mental health services on a sliding income scale which is

determined by states, to those at the highest risk for poor mental health because of the pandemic, including those who are uninsured.

The cost of the policy will need to include a high financial cost and requires support to mental health personnel. An increase in mental health services will burden the health care system, requiring new employees or a different system of care, which will be discussed later. The financial cost of the CMHRS is based on Medicare spending and total US expenditures. In 2019, the US spent $255.1 billion on mental health services nationally (Market Intelligence Team, 2020). Mental health services are not cheap, with hour-long therapy sessions ranging from $65 to $250 and any hospitalizations costing thousands at minimum (Roberts-Grey, 2020; Stensland et al., 2012). On average, Medicare will cover about 190 days of inpatient care and covers a portion of any outpatient care, but the coverage depends on the state and type of Medicare plan (Lockett, 2020). For the CMHRS to be effective, a deeper analysis of the need for mental health services is required. Currently, the CMHRS will seek to cover 80 to 100 percent of inpatient and outpatient mental health services since Medicare now proposes 80 percent coverage for outpatient care (Medicare Interactive, 2021). Medicaid is different from Medicare in that it is a priority for US citizens with low income, but the coverage widely varies state, sometimes not including mental health services, which is why the CMHRS projections are based on Medicare instead. Significant financial investment is required from the US to address the Mental Health crisis at hand.

Stakeholders and Decision Makers

The CMHRS is affected by four main groups, the federal and state government, private insurances, mental health healthcare providers, and those at risk for poor mental health. The direct beneficiaries of any policy moving forward are those at the highest risk for poor mental health due to the pandemic because they are the priority group or the CMHRS. In addition to this

group, those with the deciding power on the policy are the federal and state governments. The government has a hand in many health policies, especially under the Health and Human Services Department. In addition to federal spending for healthcare costs, the federal government decides coverage for Medicare and influences Medicaid (Medicare Interactive, n.d.). Medicaid coverage is decided in each state specifically, making states a key stakeholder in the CMHRS (Medicare Interactive, n.d.). The final group that will hold power in the policy process is the private insurance companies. The federal government can influence insurance agencies, as under the ACA, making insurance companies extremely interested in the government policy (Compilation of Patient Protection and Affordable Care Act, 2010). Since insurances are private companies, they also have some weight to the decision-making process because politicians want to keep companies happy for the economy. The CMHRS provides sufficient evidence and support to gain the approval of decision-makers.

The CMHRS is built on a faith in mental health service efficacy and the success of federal programs like Medicare, Medicaid, CHIP, and the ACA. Mental health services effectively treat patients for their issues, but it is out of the budget in many families with low income (American Psychology Association [APA], 2012). This means that if policymakers want to provide a solution that they know is effective, mental health services need to make them accessible. Medicaid covers up to 26 percent of people for mental health services, making it the nation's largest payer (Center on Budget and Policy Priorities, 2020). In addition to the number of people already covered, there is evidence for Medicaid's ability to lower out-of-pocket costs for mental health services (Golberstein & Gonzales, 2015). Government aid works to increase health care accessibility (CMS, n.d.a). Since there is evidence that mental health services are

effective, dedicating funds to make them accessible will help address the current mental health crisis (APA, 2012).

The arguments for and against the CMHRS are summed up in economic impact, national health, and implementation difficulty. The economic impact can be used as an argument for or against the CMHRS because one could argue that the cost is too high or that the economic impact of losing a workforce is higher. The cost of implementing the CMHRS is high, but it is necessary to address the issue at hand. The cost of losing the workforce due to illness is high and arguably leaves a larger impact (McDaid et al., 2019). National health is another argument that can be used in either support or opposition. One could argue that the US should invest in mental health for the sake of our nation's health, or one could argue that federal services consistently offer lower quality services (Zeiff et al., 2020). The final major argument is in implementation difficulty. The program could be as easy to implement as state mental health grants and Medicaid, following their structures, or it could be argued that it will add undue burden to the administration. This argument is like that of universal health care, but the success of Medicaid in mental health services supports the CMHRS (Golberstein & Gonzales, 2015). Since the argument is like the arguments for universal healthcare, those arguing for and against it will be similar. Those in favor will have more progressive views, leaning left, and those opposed will likely be more conservative, leaning right. Unlike the argument for universal healthcare, the CMHRS sits in a middle ground between privatized and universal insurance, allowing for some agreement between both parties.

Next Steps and Reflections

The contention between political parties is not uncommon in the current political climate in the US, and so advocating for the CMHRS will need to take that into account. One of the main

drivers in US politics is money, so the first step to advocating the CMHRS is furthering research on the impacts of COVID-19 on mental health in the US (Powell, 2013). Policy will only start to take effect when there is sufficient evidence to support the financial cost. While there is enough evidence to know there is a problem now, the extent of the mental health crisis has yet to be seen. Policymakers will need that evidence to support the policy financially.

Money is the main barrier to the policy taking place as even the progressive side of US politics is focused on ending the pandemic, as with Biden's federal mask mandate (Exec. Order No. 13,991, 2021, p. 7,045). The top priority for advocating for the CMHRS is convincing policymakers that it should be a top priority for them. At the forefront of the current conversation is the efforts to end the pandemic, and any healthcare subsidy is directed at COVID or not a priority because Medicaid already exists (Fox, 2021). Stakeholders will need more convincing as to why the subsidy should be a priority along with ending the pandemic. The best way to convince them that mental health should be a priority in the pandemic is to show them the evidence of the current mental health crisis.

Another area that policymakers will need to address is the chance of a healthcare system overload. The fear in the past has been that services will not sustain the need for healthcare (Zeiff et al., 2020). A potential solution to this issue is to restructure some mental health services to utilize psychiatric nurse practitioners more often in behavioral healthcare (Chapman et al., 2018). This change would allow for an increase in services that are more ready to meet the population's demand. Other consequences in implementing the CMHRS could be a decrease in private insurance users or an unanticipated overload of the healthcare system. These consequences would be considered and addressed in the research on the extent of the mental health crisis.

The CMHRS works as an answer to the mental health crisis because it is based on the evidence from Medicaid and our trust in mental health services (APA, 2012). COVID has caused a mass amount of mental health damage, and the aftershocks of the current pandemic will only cause more issues (Turna et al., 2021). The CMHRS works by giving aid to those most at risk for poor mental health due to the COVID-19 pandemic, thus bolstering the US's national health and economy. Private insurances may not like the policy, but it gives relief to those who the pandemic has most hurt due to social injustice, unemployment, and food insecurity (Couch et al., 2020; Millet et al., 2020; Nagata et al., 2021). Ending the pandemic is a priority, but along with that, the US must prioritize a plan to care for those who are suffering from the repercussions of the pandemic.

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