July 3, 2026

Submitted electronically to REPORTSCLEARANCEOFFICER@ahrq.hhs.gov

Subject: Great American Recovery, HHS Request for Comment on Chronic Disease of Addiction (FR Doc. 2026-11602)

Covered California is the largest state-based health insurance marketplace serving approximately 1.7 million Californians. Through its Qualified Health Plan Issuer contracts, Covered California holds health plans accountable for delivering timely, effective behavioral health care — including mental health and substance use disorder (SUD) services. The California Public Employees' Retirement System (CalPERS) is the largest purchaser of public employee health benefits in California and the second-largest public purchaser in the nation after the federal government. Through our health plan contracts, CalPERS provides healthcare to approximately 1.5 million active and retired members and their families on behalf of the State of California (including the California State University system) and nearly 1,200 public agencies and schools. Covered California and CalPERS are submitting these comments to share what we have learned from many years of embedding SUD accountability into our contracts and data infrastructure. We hope our experiences as active purchasers can inform the Department of Health and Human Services' (HHS) work to advance the Great American Recovery Initiative.

Question 1: Programs or Interventions with Rigorous, Empirical Evidence of Effectiveness

What are programs or interventions that have rigorous, empirical evidence of effectiveness in improving outcomes for substance use prevention, treatment, and recovery; mental illness prevention, treatment, and recovery; and care for co-occurring mental and chronic disease of addiction?

Expanding access to health insurance coverage has been a singular policy lever that improves access to care and treatment programs for SUD and mental health conditions. States that expanded Medicaid under the Affordable Care Act (ACA), for example, improved access to SUD treatment and increased the use of effective medications to

treat SUDs.[1] When considering the population who uses injectable drugs, those with health insurance have a three times higher incidence of receiving medication-assisted treatment (MAT), an effective, evidence-based therapy for opioid use disorder, than those without insurance.[2] Providing access to such treatment services yields the desired outcomes as detailed in the Great American Recovery Initiative. Multiple studies on the ACA's coverage expansion impact have found fewer deaths among non-elderly adults, including reduced opioid mortality rates.[3]

Successful public health programs to support substance use prevention include community-based initiatives and local clinics that expand access to services. Programs such as Communities That Care assess and equip local families, schools, and communities with a community-level prevention system to help protect against youth substance use initiation.[4]

For populations with co-occurring mental health conditions and SUDs, Certified Community Behavioral Health Clinics provide more comprehensive treatment than Community Mental Health Clinics and are more likely to have the capacity to prescribe MAT and other specialized programs.[5]

Question 2: Policy Changes to Improve Outcomes Using Existing Funding

Using existing funding, what policies or changes to federal programs might improve outcomes in substance use prevention, treatment, and recovery; mental illness prevention, treatment, and recovery; and care for co-occurring mental and chronic disease of addiction?

Currently, while health insurance plans are being paid to ensure access to high-quality mental health and substance use care, there is insufficient oversight and accountability. Of note, there have been multiple high-profile sanctions and large fines against health plans in the last three years due to compliance failures in behavioral health. Publicly announced 2023-2026 enforcement actions show at least 14 insurers and roughly $80 million in fines and penalties for behavioral health parity and access violations

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[1] Maclean JC, Saloner B. "The Effect of Public Insurance Expansions on Substance Use Disorder Treatment: Evidence from the Affordable Care Act." *J Policy Anal Manage*. 2019;38(2):366-93. PMID: 30882195; PMCID: PMC7071834.

[2] Kenneth A. Feder, Noa Krawczyk, Ramin Mojtabai, Rosa M. Crum, Gregory Kirk, Shruti H. Mehta. "Health insurance coverage is associated with access to substance use treatment among individuals with injection drug use: Evidence from a 12-year prospective study." *Journal of Substance Abuse Treatment*. Volume 96, 2019, Pages 75-81, ISSN 0740-5472, https://doi.org/10.1016/j.jsat.2018.08.012.

[3] Soni A, Wherry LR, Simon KI. "How Have ACA Insurance Expansions Affected Health Outcomes? Findings From The Literature." *Health Aff (Millwood)*. 2020 Mar;39(3):371-378. doi: 10.1377/hlthaff.2019.01436. PMID: 32119632.

[4] Oesterle, S., Kuklinski, M. R., Hawkins, J. D., Skinner, M. L., Guttmannova, K., & Rhew, I. C. (2018). "Long-Term Effects of the Communities That Care Trial on Substance Use, Antisocial Behavior, and Violence Through Age 21 Years." *American Journal of Public Health.* 108(5), 659–665. doi: 10.2105/AJPH.2018.304320. PMID: 29565666; PMCID: PMC5888048.

[5] Hu Y, Hu R, Baslock DM, Stanhope V. "Certified Community Behavioral Health Clinic Services for Clients With Co-occurring Disorders: A Latent Class Approach." *Psychiatry Serv*. 2024 Dec 1;75(12):1192-1198. doi: 10.1176/appi.ps.20230477. Epub 2024 Jul 10. PMID: 38982835; PMCID: PMC11812119.

nationwide.[6, 7, 8] When reimbursement and required remediation numbers are included, the fines increase to about $259 million across states like Georgia, Washington, Illinois and California, among others. This data suggests that enforcing policies to hold health plans accountable could be a viable path to improving outcomes and care.

At Covered California and CalPERS, we have decades of experience with effective health plan accountability, including data collection and transparency, and financial incentives for improved member health outcomes. For example, we each operate our own all-plan claims database that tracks member healthcare utilization, including behavioral health, and informs both our own policy choices and broader public accountability. We can both objectively show an increase in adult behavioral health visits per 1,000 members between 2020 and 2024, as well as broad adoption of easily accessible telehealth modalities. We have also been able to identify where there are disparities and gaps in care that need focus and new interventions. As an example, our rural dwelling populations utilize behavioral telehealth at lower rates despite high potential for benefit.[9, 10]

However, while measurement, data collection, and accountability are important, we do not support further proliferation of quality measures. Indeed, we have found that less is more. Identifying a high-impact, parsimonious set of outcomes-based measures that all stakeholders can rally behind leads to less administrative burden and waste. Rather than additional measures, federal expertise and guidance on addressing common reporting challenges may be helpful. These challenges include standardizing the narrative format of behavioral health treatment documentation, data collection workflow issues at the practice level, lack of interoperability across health IT data systems, and limited standardization of data elements for efficient exchange of behavioral health data.[11]

We recommend consideration of federal policy changes that require coordinated data collection and public reporting on substance use, mental health, and co-occurring conditions. Reviving the Centers for Medicare & Medicaid Services (CMS) Universal Measure Foundation and implementing it across all lines of business would be a meaningful first step. Consistent, comparable data is the foundation for identifying gaps,

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[6] Georgia Office of Commissioner of Insurance and Safety Fire. "Commissioner King to Fine Insurers over $20 Million for Mental Health Parity Violations." Press Release, Aug. 15, 2025, https://oci.georgia.gov/press-releases/2025-08-15/commissioner-king-fine-insurers-over-20-million-mental-health-parity.

[7] The Kennedy Forum. "States Step Up: Holding Insurers Accountable for Mental Health Parity Violations." *The Kennedy Forum*, Sept. 4, 2025, https://www.thekennedyforum.org/blog/states-step-up-holding-insurers-accountable-for-mental-health-parity-violations.

[8] Kacik, Alex. "12 Payers Recently Fined by States." *Becker's Payer Issues*, Dec. 18, 2025, https://www.beckerspayer.com/payer/3-payers-recently-fined-by-states/.

[9] Covered California. "Plan Performance Report 2025: Healthcare Evidence Initiative (HEI): Behavioral Health Domain." *California Health Benefit Exchange*, updated June 18, 2026, https://hbex.coveredca.com/data-research/plan-performance-reports/hei-behavioral-health-dashboard/.

[10] Whaley, Christopher M., et al. “The Health Plan Environment in California Contributed to Differential Use of Telehealth During the COVID-19 Pandemic.” *Health Affairs*, vol. 42, no. 1, 2023, doi:10.1377/hlthaff.2022.00464.

[11] Buchongo, Portia, Theresa Hwee, and Eric Schneider. "Behavioral Health Care Integration: Challenges and Opportunities for Quality Measurement." Issue Brief, *National Committee for Quality Assurance (NCQA)*, Aug. 2023, https://wpcdn.ncqa.org/www-prod/wp-content/uploads/NCQA-BehavioralHealthCareIntegration-Whitepaper-WEB.pdf.

directing resources, and holding programs accountable for outcomes and leveraging existing infrastructure and funding.[12]

Question 3: Reducing Stigma Against Americans Seeking Addiction Treatment

E.O. 14379 calls for Federal efforts to increase awareness of the disease of addiction and to foster a culture that celebrates recovery. How can Federal policies and programs be improved to mitigate the stigma against Americans seeking addiction treatment and recovery?

Addiction stigma is not just a social problem; it is a clinical barrier. The 2024 National Survey on Drug Use and Health found that 80% of people who needed SUD treatment nationally did not receive it.[13] Among those who recognized they needed treatment but didn't seek it, 75.5% said they thought they should have been able to handle it on their own, and 43.2% worried about what others would think, both expressions of stigma.[14] Federal investment in sustained, culturally appropriate public awareness campaigns modeled on successful chronic disease campaigns for diabetes and heart disease, can shift public perception and reduce self-stigma. Campaigns should be co-designed with people with lived experience and delivered through trusted community messengers, including faith-based organizations. HHS should fund public awareness campaigns that destigmatize addiction by recognizing it as a chronic, treatable disease and support community-based organizations serving underserved communities, including rural populations, in delivering culturally appropriate outreach and recovery support.

We also recommend requiring health plans to proactively outreach to underutilizing populations and educate them on their benefits and how to access services. Covered California requires plans to actively promote access to services and implement at least one targeted intervention per contract cycle to reach underutilizing populations. CalPERS also requires plans to actively promote access to behavioral health services, including explaining the scope and availability of such services to members. Federal programs, including Medicare, Medicaid and ACA marketplace plans, could adopt similar requirements, mandating that plans identify and actively reach members with historic rates of low utilization or known barriers.

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[12] Centers for Medicare & Medicaid Services. "The Universal Foundation: Streamlining High Priority Quality Measures for a Healthy America." *CMS National Quality Strategy*, last modified June 26, 2025, https://www.cms.gov/medicare/quality/cms-national-quality-strategy/universal-foundation.

[13] Klienschmidt, Art. “Release of 2024 NSDUH: Leveraging the Latest Substance Use and Mental Health Data to Make America Healthy Again.” *SAMSA Blog, Substance Abuse and Mental Health Services Administration*, 2024, https://www.samhsa.gov/blog/release-2024-nsduh-leveraging-latest-substance-use-mental-health-data-make-america-healthy-again.

[14] Substance Abuse and Mental Health Services Administration. “Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health.” *Center for Behavioral Health Statistics and Quality*, July 2025, Table A.56B, https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf.

Question 4: Addressing the Practitioner Supply Shortage

E.O. 14379 calls for Federal efforts to help Americans receive the treatment they need. One problem is insufficient supply of addiction and mental health counselors (a shortfall estimated by HHS-HRSA at approximately 77,050 addiction counselors and 99,780 mental health counselors). How can Federal policies and programs be improved to address this practitioner supply issue?

Lay counselors and peer support specialists offer an affordable, evidence-based way to expand behavioral health services where licensed providers are scarce, supported by over 100 randomized controlled trials demonstrating effectiveness across diverse settings.[15] California's Lay Counselor Academy found that 74% of trained lay counselors reported improved capacity to support clients, while licensed staff were freed to focus on higher-need cases.[16] Nearly every state now reimburses peer support services through Medicaid. In rural areas — where 70% of counties have no practicing psychiatrist, and 96% are entirely or partially designated mental health professional shortage areas — these providers are not a stopgap but an essential, permanent part of the care continuum.[17] Federal investment should support national scaling of lay counselor training pipelines, expanded Medicaid reimbursement for peer support services in all states, and the supervision infrastructure needed to ensure quality and safety, including expansion of the Substance Abuse and Mental Health Services Administration STAR Loan Repayment Program to better fund peer recovery specialists and community health workers.

We also recommend expanding Loan Repayment and Scholarship Programs for Addiction and Mental Health Counselors in Shortage Areas. The Health Resources and Services Administration National Health Service Corps (NHSC) and STAR Loan Repayment Program provide loan repayment and scholarships to behavioral health providers who agree to practice in underserved areas. Over 80% of behavioral health providers who graduated from these programs from 2012 through 2020 remained practicing in underserved areas as of 2021.[18] However, these programs face funding limitations and accept only a fraction of eligible applicants. Expanding funding for NHSC and STAR, broadening eligibility to include a wider range of addiction counselor credentials, and creating new scholarship pipelines through community colleges and Historically Black Colleges and Universities would help address both the quantity and diversity gaps in the behavioral health workforce. Virginia's RISE-UP program, which

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[15] Connolly, Suzanne M et al. “Mental health interventions by lay counsellors: a systematic review and meta-analysis.” *Bulletin of the World Health Organization.* vol. 99,8 (2021): 572-582. doi:10.2471/BLT.20.269050.
[16] Prism Partners Group. “Strengthening the Behavioral Health Workforce: Evaluation of the Lay Counselor Academy.” *California Health Care Foundation*, 18 Apr. 2025, https://www.chcf.org/resource/strengthening-the-behavioral-health-workforce-evaluation-of-the-lay-counselor-academy/.
[17] Silverman, Karla. “Leveraging Peers and Lay Counselors to Address Behavioral Health Care Workforce Shortages in Rural Areas.” *Center for Health Care Strategies*, Oct. 2025, https://www.chcs.org/resource/leveraging-peers-and-lay-counselors-to-address-behavioral-health-care-workforce-shortages-in-rural-areas/.
[18] U.S. Government Accountability Office. “Behavioral Health: Available Workforce Information and Federal Actions to Help Recruit and Retain Providers.” *GAO-23-105250*, 27 Oct. 2022, https://www.gao.gov/assets/gao-23-105250.pdf.

provides $10,000 stipends to clinical mental health counseling students for rural internships, offers another replicable model.[19]

Question 5: Strengthening HHS's Ability to Evaluate Program Effectiveness

How can HHS strengthen its ability to evaluate the effectiveness of substance use and mental health prevention, treatment, and recovery programs and initiatives? How can the Department leverage data modernization, advanced analytics, and emerging technologies such as artificial intelligence to enable performance measurement on a real-time or continuing basis?

Covered California and CalPERS' experience demonstrates that standardized, publicly reported measures are essential for identifying performance gaps and directing resources where they are most needed. HHS should require all federally funded SUD and mental health programs to collect and report a standardized set of measures. The $20 million Behavioral Health IT initiative, which tests a standardized set of behavioral health data elements to ensure interoperability across providers, states, and federal programs provides a strong foundation for this work and should be expanded. [20] Disaggregated data by geography, language, income, and other demographic factors are essential to ensuring that programs reach all Americans.

Conclusion

Covered California and CalPERS experience shows that health plans are a critical lever to improve behavioral health outcomes. Enhancing health plan requirements, ensuring robust data infrastructure and accountability for outcome-focused measures, can drive meaningful progress on SUD outcomes. The foundation of that progress, however, is coverage: when individuals have stable, accountable health insurance, they are more likely to access the evidence-based interventions described above, remain engaged in treatment, and achieve lasting recovery. Federal programs that strengthen coverage continuity, align quality standards across payers, and invest in data infrastructure will produce the most durable improvements in outcomes for Americans living with addiction and co-occurring mental health conditions.

Covered California and CalPERS support the Great American Recovery Initiative's recognition that addiction is a chronic, treatable disease requiring a coordinated federal

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[19] Whaley, Christopher M., et al. “The Health Plan Environment in California Contributed to Differential Use of Telehealth During the COVID-19 Pandemic.” *Health Affairs*, vol. 42, no. 1, 2023, doi:10.1377/hlthaff.2022.00464.
[20] “ASTP/ONC Announces Selection of Nationwide Pilot Programs to Improve Behavioral Health Data Exchange.” *Office of the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC)*, 4 Feb. 2026, https://www.healthit.gov/news/astp-onc-announces-selection-of-nationwide-pilot-programs-to-improve-behavioral-health-data-exchange/.

response, and hope our perspective as active purchasers is useful as HHS shapes its next steps. Together, we welcome the opportunity to continue this conversation.

Please do not hesitate to contact Julia Logan, CalPERS Chief Clinical Director, at (916) 795-0404, or Danny Brown, CalPERS Chief of the Legislative Affairs Division, at (916) 795-2565; Monica Soni, Covered California's Chief Medical Officer, at (916) 954-3225, or Kelly Green, Covered California's Director of External Affairs and Community Engagement, at (916) 228-8309, if we can be of any assistance.

Sincerely,

S. Monica Soni, MD
Chief Medical Officer
Covered California

Julia Logan, MD, MPH
Chief Medical Officer
CalPERS