

Mental Health Liaison Group

September 24, 2009

The Honorable Max Baucus
Chairman
Senate Finance Committee
Washington, DC 20510

Dear Chairman Baucus:

The undersigned organizations in the Mental Health Liaison Group (MHLG) are writing to express our support for your modified draft health reform legislation, "America's Healthy Future Act." We commend you for your leadership, vision and ongoing efforts to further access to affordable and quality health care services. We greatly appreciate the bill's significant focus on MHLG priorities as discussed in our May 12 letter to the Leadership (<http://www.mhlg.org/05-12-09.pdf>).

Health Reform and Exchange Issues

The inclusion of mental health and substance use disorder services in essential benefit packages is vital. By requiring that all plans comply with state and federal laws, you will continue the good work of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act by requiring that these services are provided at parity with medical/surgical services. We are pleased that the Committee accepted by voice vote an amendment reaffirming that the Act applies to plans in the Exchange.

The elimination of cost-sharing for preventive care in the essential benefits package will help assess whether overall health care costs are lowered by lower cost preventive care. The fostering of national prevention and wellness strategies holds great promise for helping slow the growing cost of treating chronic illness. We are pleased the Substance Abuse and Mental Health Services Administration will be consulted on the development of prevention and wellness strategies pertaining to behavioral health. That agency will have input, when appropriate, in working groups, committees, task forces and other newly established federal entities on issues pertaining to behavioral and mental health to address, specifically, prevention of mental illness and substance use disorders.

The bill includes significant insurance market reforms. Specifically, we support the provisions that prohibit insurers from imposing pre-existing condition limitations on individuals as well as limit insurers' ability to rate individuals on the basis of health status, medical history, gender, occupation, past claims experience, disability, receipt of health care and evidence of insurability. The guaranteed renewal and guaranteed issue rules that will be so helpful to consumers will also ensure that solo health care practitioners are able to purchase and retain insurance in the individual market. The ban on the use of annual and lifetime dollar limits will help persons with serious acute illness as well as chronic conditions. Consumers will also be greatly helped by the bill's caps on premiums and out of pocket spending.

National organizations representing consumers, family members, advocates, professionals and providers

We urge the removal of the age rating provisions which would allow health insurers to charge patients different premiums based solely on age. These provisions are unduly discriminatory against older adults, many of whom have chronic conditions or may acquire disabilities. Such increased premiums for this population may serve as a mechanism for discriminating against individuals with pre-existing conditions.

We applaud the proposal's inclusion of language in support of integrated care models to promote a team based approach to health care. Integrated or interprofessional health care is an approach characterized by a high degree of collaboration and communication among health professionals. What makes integrated health care unique is the sharing among team members of information related to patient care and the establishment of a comprehensive treatment plan to address the biological, psychological and sociocultural needs of the patient. The benefits of an integrated health care approach that includes both physical and mental health extend to patients, caregivers, health care providers, and the health care system at large. The health care team includes a diverse group of members depending on the needs of the individual.

We are encouraged by the language that would require states to ensure that all children of parents who choose the state exchange coverage would continue to receive the benefits, including early and periodic screening, diagnostic and treatment (EPSDT) benefits, to which children are entitled under Medicaid. We hope that the provisions are strong enough to ensure access to critical services and alleviate confusion and complexity for families attempting to navigate the provision of health care services for their children.

We hail the bill's commitment to workforce development within the primary care and public health areas. We appreciate the commitment to implementing strategies which will address workforce shortfalls and improve the availability of health care professionals in these areas, including mental health and substance use disorder professionals.

We strongly support the Chairman's new requirements applicable to section 501(c)(3) hospitals that they be required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the community needs identified through such assessment. The inclusion of such a requirement ensures that hospitals are responsive to the needs of their communities and that they provide adequate and appropriate health care services. In particular, this provision has the potential to significantly impact efforts to address health disparities on behalf of vulnerable populations who may make up a significant portion of the community served by a hospital. The provisions in this section of the bill illustrate the commitment of the Finance Committee to the creation of hospitals that are responsive to health needs of their communities.

We applaud the language within the Chairman's Mark that would prohibit cost-sharing (including premiums, deductibles, copayments, co-insurance, etc.) for all American Indians and Alaska Natives with incomes at or below 300 percent of FPL for state exchange plans and public programs. In addition, we support the change in policy for individuals simultaneously covered by Medicaid and other insurance or programs to ensure that Indian tribes, tribal organizations and urban Indian organizations are the payers of last resort.

We are thankful for the proposal's *Subtitle H- Health Disparities* which will establish uniform categories for collecting data on race and ethnicity, gender and primary language and will also expand the Office of Management and Budget's Directive 15 standards to Medicaid for the aggregation and allocation of subgroups for race and ethnicity data. We also strongly support the language that all federally-funded population surveys include provisions to collect data on race, ethnicity, gender, disability and primary language. However, we would also encourage the Committee to consider the inclusion of sexual orientation and gender identity as an additional category required for data collection. This population is diverse and very little reliable health data exist for it. However, preliminary research shows that some key health concerns for this population include certain cancers, HIV and AIDS, Hepatitis A and B, mental health issues, sexually-transmitted diseases, and violence and sexual assault.

We have some concerns that rehabilitation and habilitation services, therapies, and durable medical equipment and devices are not explicitly included under the minimum benefits package. Rehabilitative and habilitative services can be critical to someone with a disability or mental health condition. They are necessary to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning as a result of an illness, injury, disorder or other health condition. These services are also vital to the prevention of secondary disabling conditions.

We are concerned that the "free rider" provision will negatively affect those with families, minorities and low SES, particularly low-income women. The provision requires employers of firms with 50 or more employees who do not offer health coverage to pay the average subsidy cost per person for all employees who are eligible for a subsidy and who purchase coverage in the new health care plan. Employees whose family income is below about \$67,000 for a family of four qualify for a subsidy. However, employers would not have to pay for employees with higher family incomes. Single mothers in low paying jobs earn less than the average male and would require a higher subsidy, providing a disincentive for employers to hire and cover them. We recommend replacement of this provision with language that encourages employers to ensure quality health insurance for their employees.

Everyone in our country should have access to quality health insurance. We urge the Committee to raise the amount of subsidies to enable more low-income families to buy health insurance.

Furthermore, we support needs assessments for recipients of the Maternal Child Health (MCH) block grant to identify those at risk for poor maternal child health. The bill would also implement a home visitation program. The MCH block grant provides critical support for perinatal services for low-income women. According to data from the Centers for Disease Control and Prevention, 18 percent of women report being moderately to very depressed after the delivery of their baby. Needs assessments will help identify the mothers most at risk for perinatal depression and in need of home visitation.

The MHLG has a longstanding interest in ensuring that state mental health and substance use mandated benefits and parity laws are preserved for consumers during consideration of federal

health care legislation. States have enacted these laws over many years to ensure that mental and substance use coverage adequately protects their citizens. For this reason, we urge that the Committee delete provisions of the draft legislation that would create new “national” plans that could provide coverage to consumers without having to comply with these mandated benefits and parity laws.

Medicare Issues

Your legislation also addresses shortcomings in current Medicare policy. We appreciate your extending for two years the restoration of reimbursement cut from outpatient psychotherapy services, which will help maintain the viability of the Medicare outpatient mental health benefit. The impending 21% cut in reimbursement for independent professional services under Part B is averted and replaced by a half percent increase in 2010 reimbursement.

Medicare’s limited coverage of mental health professionals, reducing beneficiary choice of provider, would be eased by your approval of Section 1308 of H.R. 3200. This would expand the cadre of state-licensed providers who would be directly reimbursed for services to Medicare beneficiaries. The program’s limited coverage of mental health services for nursing home residents would be significantly expanded with the inclusion of Section 1307 from H.R. 3200. Addition of this section would cover clinical social work services to nursing home resident stays paid under Medicare.

The inclusion of a Medicare medical home pilot project will be a good way to see how successful this approach to health care delivery will be in reducing health care costs and coordinating health care services. However, as the mind and body are connected, mental health and substance use disorder treatment professionals should be clearly included in these homes, which would better be called “health care homes.”

Medicaid Issues

Medicaid beneficiaries also benefit from proposals in your legislation. Medicaid is an important source of coverage for individuals with low-incomes, including those with a mental illness who benefit from a range of services. The raising of eligibility to 133% of the Federal Poverty Level (FPL) extends these benefits to millions of Americans who are currently uninsured, among them childless single adults. This coverage expansion is particularly critical for low income persons with mental illness and addiction disorders. According to the Kaiser Family Foundation, one of five individuals below 150% FPL has a significant mental disorder including major clinical depression, schizophrenia and bipolar disorder.

We urge you to ensure all newly eligible Medicaid enrollees (up to 133% of FPL) will receive adequate health care coverage. Health insurance coverage provided through Section 1937 of the Deficit Reduction Act of 2005 is inadequate for this vulnerable population and must not be considered. Additionally, it is our hope that continued improvements will be made to ensure that Medicaid coverage expansions are implemented at the same time as other coverage expansions, without delay.

We support your authorization of a new state Medicaid option promoting health homes and integrated care that would allow individuals with serious mental illness to receive integrated care and for community mental health centers to serve as designated providers under this option. For instance, as it relates to disability, more than 25 percent of individuals with disabilities have a mental health condition. A significant portion of individuals enrolled in Medicaid receive services for persistent and severe mental illness. When appropriate the state will consult and coordinate with the Substance Abuse and Mental Health Services Administration specifically in addressing the prevention and treatment of mental illness and substance use disorders.

We support the creation of a new Office of Coordination for Dual Eligible Beneficiaries. Furthermore, we believe the additional flexibility offered to states by allowing up to five year approval for Medicaid waivers serving dual-eligible beneficiaries (including section 1115 and 1915 waivers) would be beneficial to individuals utilizing the services. We also support the concept of a demonstration project to evaluate the use of bundled payments for acute and post-acute care and/or concurrent physician services in so far as such services include critical mental and behavioral healthy services.

We applaud the provision to establish the community first choice option, which would create a Medicaid state plan option to provide home- and community-based attendant supports and services to individuals with disabilities who would otherwise be served in institutions. We also praise the addition of the provision clarifying coverage of therapeutic foster care services under Medicaid.

Enactment of these provisions in your bill would make a great difference in the lives of persons with mental and behavioral disorders. Through research we have an unprecedented arsenal of effective treatments for mental and behavioral disorders. Today, mental disorders are as treatable as medical conditions. These treatments must be made available to all Americans who need them. We appreciate your interest in ensuring Americans have adequate access to effective mental health treatments, and we wish to work with you to pass through the Congress comprehensive reform legislation this year.

Sincerely,

Alliance for Children and Families
American Association for Geriatric Psychiatry
American Association of Pastoral Counselors
American Group Psychotherapy Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Psychotherapy Association
Anxiety Disorders Association of America

Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health Law
Center for Clinical Social Work
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Child Welfare League of America
Clinical Social Work Association
Clinical Social Work Guild 49, OPEIU
Depression and Bipolar Support Alliance
Mental Health America
NAADAC, the Association for Addiction Professionals
National Alliance on Mental Illness
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders – ANAD
National Coalition of Mental Health Consumer/Survivor Organizations
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Mental Health Planning & Advisory Councils
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Federation of Families for Children’s Mental Health
National Foundation for Mental Health
Suicide Prevention Action Network USA, a Division of AFSP
Therapeutic Communities of America
Tourette Syndrome Association
United Neighborhood Centers of America*
U.S. Psychiatric Rehabilitation Association
Witness Justice

* *not an MHLG member*