



Statement of

David L. Shern, Ph D
President and CEO, Mental Health America

before the

Energy and Commerce Committee
Health Subcommittee

Hearing on Health Care Reform

June 23, 2009

Mr. Chairman and members of the Committee, Mental Health America is honored to participate in today's hearing on ways to reform our health care system to cover the uninsured and improve the quality of care while reducing cost. While this is an ambitious goal, we believe the draft bill issued by the Chairmen of the Ways and Means, Energy and Commerce, and Education and Labor Committees last week would start us on the right path toward achieving quality, affordable health care for all Americans.

For over one hundred years, Mental Health America, previously known as the National Mental Health Association, has advocated for the interests of mental health consumers. Along with over three hundred affiliates across the United States, we raise the concerns of those who are often excluded or discounted, even in health care discussions. And we applaud your decision to highlight the importance of addressing the needs of people with mental health and substance use conditions by inviting us here today. We also appreciate the many important provisions in the Tri-Committee bill that recognize how integral behavioral health (which encompasses mental health and substance use) is to overall health and the critical need to fully incorporate the goal of improved availability and quality of preventive, treatment, and rehabilitative services for these conditions into our broader health care reform efforts.

People with mental health and substance use conditions have traditionally not been well served by our current health care system. The President's New Freedom Commission on Mental Health proclaimed in 2002 that mental health care in this country is in shambles.¹ We could not agree more, although there are isolated examples of excellent care. And, scientific advances over the last half century have led to reliable diagnosis and a range of treatments for these conditions with effectiveness rates comparable to or exceeding those of treatments for many other health conditions.

¹ President's New Freedom Commission on Mental Health, Interim Report, October 2002, Washington, D.C. [available at www.mentalhealthcommission.gov]

Tragically, despite such significant advances in our understanding of how to effectively treat behavioral health conditions, people with serious mental illnesses who are treated in our public systems die on average 25 years earlier than the general population due primarily to other co-occurring health disorders including diabetes, heart disease, cancer, and asthma.² Behavioral health consumers have some of the greatest unmet needs for improved care coordination and prevention services.

Mental health and addiction treatment have historically been subject to blatantly discriminatory limits on coverage through private insurance plans that block access to effective and critically needed therapies. And more insidious but no less devastating has been the more aggressive management of care for these conditions than for other health conditions through utilization management and other treatment limitation techniques. A recent report found that about two-thirds of primary care physicians could not get outpatient mental health services for their patients – a rate that was at least twice as high as that for other services – due in part to health plan barriers and inadequate coverage.³

Last year, we made tremendous progress working together on this front with enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Pub L. 110-343) to prohibit unequal treatment limits and financial requirements for mental health and substance use benefits compared to medical and surgical benefits. Groundbreaking as well were improvements to Medicare coverage of mental health treatment through the Medicare Improvements for Patients and Providers Act (MIPPA) (Pub. L. 110-275) -- especially the provision phasing out the higher 50 percent coinsurance rate for outpatient mental health services.

We are very pleased to see that the principle of non-discrimination and parity for behavioral health services would be maintained in the new Health Insurance Exchange and health care coverage provisions proposed in the Tri-Committee bill. In light of the long history of discrimination against individuals with behavioral health conditions, we also strongly support the insurance market reforms in the bill that would establish a guaranteed issue requirement and prohibit pre-existing condition exclusions and premium rating based on health status as well as annual and lifetime limits on benefits. In addition, we appreciate the provision to repeal the discriminatory 190-day lifetime limit on psychiatric hospital inpatient care under Medicare.

As we have seen, particularly in the Medicaid program, when funding is tight and benefits are reduced, behavioral health services are often the first place cuts in coverage are made. However, providing access to behavioral health services will be essential in light of recent research showing that a large proportion of low-income, uninsured individuals have poor mental health.⁴

² Parks, J., Svendsen, D., Singer, P., Foti, M., Mauer, B., Morbidity and Mortality in People with Serious Mental Illness, National Association of State Mental Health Program Directors, 2006.

³ Cunningham, P.J., Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care, Health Affairs, April 2009.

⁴ Kaiser Commission on Medicaid and the Uninsured, Policy Brief entitled "Low-Income Adults Under Age 65 – Many are Poor, Sick, and Uninsured", June 2009.

Thus, the provision in the Tri-Committee bill to ensure that mental health and substance use services are available to all individuals covered through the new Health Insurance Exchange is absolutely critical.

In light of the high degree of mental health needs among the uninsured population, we commend the efforts of so many in Congress and the Administration to expand health care coverage to all. And, we strongly support the provision requiring outreach to vulnerable populations to inform them about the Exchange, including individuals with mental health conditions. As we have learned through implementation of the Medicare Part D program, additional efforts will be needed to ensure that those with serious mental health conditions are aware of the program and can successfully enroll. Mental health providers and other organizations that regularly interact with individuals with behavioral health conditions can provide valuable assistance in educating these individuals about the new coverage program and helping them navigate it.

Prescription medication is often a key component of effective behavioral health care and we have been actively working to ensure that the Medicare Part D program provides comprehensive coverage of medications to treat these conditions. The gap in coverage commonly referred to as the “doughnut hole” has proven very burdensome for many mental health consumers and we frequently hear from consumers unable to access critical medications because of this gap in coverage. Thus we strongly support the provision to phase out the doughnut hole.

We would also encourage the Committee to include language in the bill to strengthen the protection established administratively by the Centers for Medicare and Medicaid Services (CMS) to ensure full coverage of six classes of clinically sensitive medications. CMS put this requirement in place out of concern that the diseases associated with these six classes have among the highest predicted drug and medical costs and the risk that individuals with these conditions may be discouraged from enrolling or denied needed medications due to discriminatory tactics. These concerns were well-founded and Medicare beneficiaries with these conditions, including behavioral health conditions, continue to need assurance that Part D will provide access to substantially all medications in these classes.

As more individuals with mental health conditions receive health care coverage, it will be important to ensure the availability of behavioral health service providers. We thus strongly support the grant program proposed in the Tri-Committee bill increasing the public health workforce that identifies mental health as a severe shortage discipline and the expansion of the National Health Service Corps which includes behavioral health professionals. We also appreciate the provision in the bill to allow Medicare coverage for mental health counselors and marriage and family therapists and to maintain Medicare reimbursement levels for outpatient mental health services which hopefully will help to increase access to behavioral health through Medicare and the broader health care system.

Many of the uninsured have disabling mental health conditions but have for one reason or another not been designated as disabled under federal programs and thus eligible for Medicaid and/or Medicare. However, it will be important to ensure that these individuals receive care, at

least initially, through the traditional Medicaid program which provides community-based support services which may not be offered through private plans in the Exchange. The two-year waiting period for individuals with disabilities to receive Medicare coverage should also be addressed since some 40 percent of people with disabilities, including many with behavioral health conditions, are without health care coverage at some point during their wait for Medicare. We recognize that some of these individuals would be covered in the Exchange and encourage the Committee to keep the high needs of this population in mind as health care reform legislation develops.

We also strongly support the provision in the bill to ensure that plans in the Exchange provide rehabilitative and habilitative services, which hopefully would encompass some of the same types of community-based services covered by Medicaid. This provision is critical to overcoming the high degree of unemployment among those with serious mental health conditions. Despite the fact that many are willing to work and would benefit from the socialization and positive reinforcement that engagement in employment can offer, a powerful disincentive to getting a job is currently created by the risk of losing Medicaid coverage and thus access to critically needed community-based services.

Moreover, resources could not be more efficiently spent than on improving care for behavioral health conditions because they are among the most chronic and disabling conditions affecting the U.S. population. In fact, the World Health Organization has pronounced mental health disorders to be the leading cause of disability in the United States based on burden of disease.⁵ And severe mental illnesses cost the U.S. \$193 billion in lost wages in 2002⁶ which exceeds the gross revenue of 499 of the Fortune 500 Companies.

Mental illnesses often accompany and greatly increase the cost of treating other chronic conditions. Prevalence studies have found depression to be commonly associated with diabetes, asthma, heart disease, and obesity. Research has also shown that individuals with these health conditions who also have a mental health disorder, such as depression, are likely to experience worse functional disability, a poorer quality of life, and, in some instances, higher mortality, than individuals whose chronic / health conditions are not co-morbid with mental disorders.⁷ One study has even indicates that depression contributes to the risk of heart disease as much as diabetes, high cholesterol, or obesity.⁸ The most tragic outcome of this high degree of co-morbidity, as mentioned earlier, is the finding that individuals with serious mental health conditions die 25 years earlier than the general population due to inadequate care for co-morbid health conditions.

⁵ The World Health Organization, The World Health Report 2004: Changing History, Annex Table 3: Burden of disease in DALYs by cause, sex, and mortality stratum in WHO regions, estimates for 2002.

⁶ Kessler, R.C., Heeringa, M.D., Lakoma, M.P., Rupp, A.E., Schoenbaum, M., Wang, P.S., and Zaslavsky, A.M., Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication, Am J Psychiatry, May 7, 2008.

⁷ Von Korff, M., Scott, K., Gureje, O, eds., Global Perspectives on Mental Disorders and Physical Illness in the WHO World Mental Health Surveys, (New York: Cambridge University Press, forthcoming).

⁸ Sherrer, J.F., et al, "Depression Is a Risk Factor for Incident Hear Disease in a Genetically Informative Twin Design" (paper presented at the annual meeting of the American Psychosomatic Society, Chicago, Illinois, 4-7 March 2009).

Thus we strongly support provisions in the Tri-Committee bill to improve chronic care management through medical homes and other models. We encourage the Committee to ensure that the medical home programs that would be funded through Medicare and Medicaid under the bill would include behavioral health specialists on the treatment teams established and also that mental health or addiction treatment facilities would be allowed to serve as medical homes. In addition, we also strongly support the provisions to increase reimbursement for primary care and community health centers but encourage the Committee to also include community mental health centers in these initiatives because these facilities generally provide a full range of services including the case management so crucial to improving care coordination and access to primary care for individuals with behavioral health conditions. We also applaud the program to enhance primary care training that targets vulnerable populations including individuals with mental health conditions.

Half of all people with a mental health diagnosis first experience it by age 14, but will not receive treatment until age 24.⁹ Because of this early age of onset and ten year delay in treatment, these conditions often interfere with a young person's ability to succeed in school and gain employment and increase the likelihood of developing a costly disability. Moreover, research indicates that childhood adverse experiences and early onset mood and anxiety disorders may significantly increase the risk of a wide array of chronic physical diseases later in life.¹⁰ Thus, Mental Health America has placed a high priority on improving access to preventive services and mental health promotion as a key component of health care reform.

In March, the Institute of Medicine (IOM) issued a report on "Preventing Mental, Emotional, and Behavioral Disorders among Young People" illustrating the dramatic impact these conditions have on our population but also the tremendous opportunity we have to prevent them.¹¹ In recent decades there has been an explosion in research on the prevention of mental health and substance use conditions. Many interventions can result in long term reductions in behavioral health disorders as well as other positive outcomes such as improved academic achievement. The report asserts that the greatest prevention opportunity is among young people and highlights the finding that there is a window of opportunity from the time a symptom first appears to development of a diagnosable disorder, usually two to four years. A number of successful interventions focus on improving parenting skills and mitigating disruptive family influences such as divorce and maternal depression, as well as engaging schools in prevention initiatives.

Thus we are heartened by the many provisions in the Tri-Committee bill to improve access to preventive services including the requirement that plans in the Exchange cover screening services without cost-

⁹ Kessler R.C., Berglund P., Demler O., et al., Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, Arch Gen Psychiatry, 2005; 62:593-602.

¹⁰ Von Korff, M., Scott, K., Gureje, O, eds., Global Perspectives on Mental Disorders and Physical Illness in the WHO World Mental Health Surveys, (New York: Cambridge University Press, forthcoming).

¹¹ National Research Council and Institute of Medicine, "Preventing Mental, Emotional, and Behavioral Disorders among Young People," Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Eds., Washington, D.C., The National Academies Press, March 2009 [http://www.bocyf.org/prevention_policymakers_brief.pdf]

sharing as well as well-child checkups (although it would be helpful to also stress the importance of mental health screenings and education as part of these check-ups). Also important are the provisions requiring Medicare and Medicaid to cover preventive services without cost-sharing requirements. We also strongly support the proposal that would include a behavioral health specialist on the new “Task Force on Clinical Preventive Services” and the proposal to establish stakeholder advisory boards that would give consumers input into the workings of the clinical and community preventive services task forces.

In light of the IOM report which discussed the strong evidence showing the effectiveness of nurse home visitation programs, we strongly support the proposal to allow states to cover these services through their Medicaid programs. We also encourage the Committee to specify that evidence-based variations on the nurse home visitation program could also be covered. The provision requiring Medicaid coverage of services provided by school-based health clinics if covered in a physician’s office is also important because the best way to ensure children receive vital health care services is to make those services available where the children are most of the time.

Many of the most effective behavioral health prevention programs are community-based including working with schools to engage them in practices that strengthen social and emotional development while fostering a positive learning environment and mental health literacy. Thus we strongly support proposals in the bill to strengthen the Task Force on Community Preventive Services and establish community-based prevention and wellness research grants and services grants that would cover services recommended by this task force or another comparable review body.

We also appreciate the provisions in the Tri-Committee bill to improve the quality of care, including through enhanced support for comparative effectiveness research (CER). Consumers/patients should be fully represented in all phases of research priority-setting, development, and interpretation. Consumers/patients bring valuable perspectives and expertise to discussions regarding research priorities and how clinical research should be conducted. As the individuals most personally and forcefully affected by the outcomes of this research, consumers/patients should be considered the primary audience and ultimate end users of this information, but their voices are rarely heard in discussions which determine the direction clinical research and comparative effectiveness research (CER) should take. It is vitally important that consumers/patients be well-represented at all levels of oversight and on any entity charged with setting national priorities and distributing federal funding for comparative effectiveness research.

Thus, we support the proposal to establish a clinical perspective advisory panel for each research priority which would consult with patients and advise the Center for CER on research questions and methods to ensure the information produced is clinically relevant to decisions made by clinicians and patients at the point of care. We encourage the Committee to ensure that each advisory panel include several consumer/patients that would be most affected by the research and provide educational and other support to enable them to effectively participate. We also

appreciate the proposal in the bill to establish a patient ombudsman to serve as a point of contact for any patients interested in CER studies and to ensure any comments from patients on proposed studies are heard. In addition, we support the provision requiring that the research take into account the potential for differences in the effectiveness of health care items and services used with various subpopulation such as racial and ethnic minorities, women, different age groups, and individuals with different co-morbidities.

Finally, we support the provision requiring Agency for Healthcare Research and Quality to establish quality measures for the delivery of health services and would suggest that behavioral health services be included in this effort since these conditions are some of the most chronic and costly conditions. Quality measures would help provide incentives to providers to use best practices and help identify consumers who are not receiving care that complies with treatment guidelines.

Again, thank you for the opportunity to testify, and I look forward to answering any questions the Committee members may have.